DOCUMENT RESUME

ED 323 457 CG 022 780

AUTHOR	Kempley, Frances A.; And Others
TITLE	Youth at Risk: A Resource for Counselors, Teachers and Parents. Part 3. Working with Youth at Risk: Behavioral Issues and Interventions.
INSTITUTION	American Association for Counseling and Development, Alexandria, VA.
PUB DATE	89
NOTE	178p.; For parent document, see CG 022 777.
PUB TYPE	Collected Works - General (020)
EDRS PRICE	MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS	Acquired Immune Deficiency Syndrome; Adolescent Development; *Adolescents; Anorexia Nervosa; *At Risk Persons; *Behavior; Bulimia; Early Parenthood; Pregnancy; School Counselors; Secondary Education; Substance Abuse; Suicide; Unwed Mothers; *Youth Problems
IDENTIFIERS	*Eating Disorders; Gangs

ABSTRACT

This document consists of Part 3 of a book of readings on at-risk youth designed to provide information and strategies for counselors, teachers, parents, administrators, social workers, and others who work with youth at risk. It includes six readings, each dealing with a specific behavior that places a young person at risk. "The Secret and All-Consuming Obsessions: Anorexia Nervosa and Bulimia Nervosa" (Frances Kempley & Wanda Weber) addresses anorexia nervosa and bulimia nervosa from a female perspective, stresses signs and symptoms that alert the helping professional, and presents theories of both causation and treatment to deal with the problem. "Female, Single, and Pregnant: Adolescent Unwed Mothers" (Rosemary Thompson & Ardis Sherwood) considers the extent of the problem, needs of the adolescent mother, and intervention methods. Exemplary prevention and intervention programs are presented. "No Guarantee of Immunity: AIDS and Adolescents" (Lizbeth Gray & Reese House) provides information on Acquired Immune Deficiency Syndrome needed by the helping professional who works with adolescents. "'I Don't Want to Live': Suicidal Behavior" (Dave Capuzzi & Douglas Gross) considers the extent of the problem, signs and symptoms, and causation and treatment modalities. "Tough Enough: Gang Membership" (Alcena Boozer) examines the youth gang phenomenon, presenting information on youth especially at risk of gang involvement. "'Why Say No?': Substance Abuse Among Teenagers" (Sharon Robinson) examines adolescent substance abuse from a variety of perspectives--psychosocial, historical/legal, and psychophysiological. (NB)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED323457

Part III

WORKING WITH YOUTH AT RISK: BEHAVIORAL ISSUES AND INTERVENTIONS

CG022780

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION
CENTER (ERIC)

☐ This document has been reproduced as received from the person or organization originating it.

☑ Minor changes have been made to improve reproduction quality

---

- Points of view or opinions stated in this document do not necessarily represent official OERI position or policy

"PERMISSION TO REPRODUCE THIS
MATERIAL IN **MICROFICHE ONLY**
HAS BEEN GRANTED BY

Mark Hamilton

TO THE EDUCATIONAL RESOURCES
INFORMATION CENTER (ERIC)."

Chapter 8

THE SECRET AND ALL-CONSUMING OBSESSIONS: ANOREXIA NERVOSA AND BULIMIA NERVOSA

Frances A. Kempley and Wanda L. Weber

All four members of the eating disorders group are sitting in a circle waiting for Dr. Jones to arrive. The group includes three female adolescents and one male adolescent. John is on the wrestling team and looks like the picture of health. Mary, whose weight is normal, is a very attractive cheerleader. Teresa is a gymnast. She is well groomed but extremely thin. Jane is an honors student who wears several layers of loose clothing to disguise her emaciated appearance.

Although the group is small, the members are conscientious and attend each meeting. Although regular attendance is not always the case in eating disorders groups, these members were carefully chosen by Dr. Jones. They are all receiving other forms of counseling in addition to the group. The group is special to these members because it is the one place in which they can share their feelings about food and about themselves with their peers and not feel abnormal. Dr. Jones enters the room and the group begins.

Dr. Jones: "Does anyone want to begin our session with some current concerns?"

Jane, typically not as vocal as the others, speaks first.

Jane: "Ever since I was released from the hospital and returned to school, I notice other students staring at me in the halls and in the cafeteria. It's really bothering me."

Dr. Jones: "Have you come to any conclusions as to why people are staring at you?"

Jane: "I think it's because I've gained so much weight and everyone thinks I'm fat. I know that *I* think I'm fat."

Dr. Jones: "Sometimes how we feel and what is in fact true are very different. I understand that you feel fat right now and that this feeling is real to you, but I wonder whether others see you as fat. Would you like to get some feedback about your appearance from the other group members?"

Jane: "Yes, I would, although I don't know if I will believe them."

John: "People stare at you because you're so thin, not because you're fat."

Mary: "I agree that you are too thin. You really look very fragile. But I'm not too thin, and sometimes I feel like people are staring at me, too, in the cafeteria."

Dr. Jones (to Mary): "When you feel self-conscious in the cafeteria, what are you thinking about?"

Mary: "I'm wondering whether the others know that I binge. I never do it at school because there are too many people in the bathroom and I won't be able to purge. I do know other girls who don't seem to care if they are found out, but I do. I would die if anyone in my classes knew about my problem."

Dr. Jones: "Does anyone else feel like Mary—self-conscious when you eat and afraid that others will find out that you have an eating disorder?"

Teresa: "I do. I never feel comfortable eating in front of anyone. I try to eat salads when I'm around other people so they won't know how I 'pig out.' People would never guess from my size how much I put away. I usually binge and purge when I'm alone, but sometimes I do it around my family and that drives them crazy."

Mary: "I always start each day with a promise to stay on a diet. I try to stay away from food so that I won't binge, but when I get home from school, I just lose control."

Jane: "I have never binged and have always been able to diet. People told me how much they envied my control. I felt kind of special. And now people are telling me that I need to eat. It's easier to stay away from food altogether. I'm afraid that now that I've gained 5 pounds I'll just keep gaining. I'm terrified and feel out of control."

John: "I get terrified too. I'm afraid I'll get fat again if I don't purge. When I was a kid, I got teased a lot and was never picked to be on any teams. I never want to be rejected again."

Dr. Jones: "It sounds like all of you are afraid of losing control of your weight and of your eating. Do you ever feel afraid of being out of control in other areas?"

Teresa: "I feel totally out of control all the time except right after I binge and purge. The binging and purging gives me a kind of peace of mind for a little while until I start feeling rotten again. The bad feelings always seem to creep back."

Dr. Jones (to Teresa): "Can you describe some of these bad feelings?"

Teresa: "Before I began counseling, I couldn't even identify the feelings, but I'm gradually becoming aware that I'm sometimes disappointed and angry with my family."

Dr. Jones: "Are you aware of what disappoints and angers you the most?"

Teresa: "My parents are always fighting with each other despite the fact that they pretend to be happy outside the house. The only thing they agree on is that they want me to stop binging and purging. I make them look bad and spoil their image."

Jane: "My family never argues. Actually I'm not sure what any of them feel or what I feel. I do think they've given me a lot more attention since I've been sick."

Dr. Jones (to Jane): "It sounds like you have gotten praise in the past for your dieting and are now getting more attention from your family because of your eating disorder. Do you see any negatives to the way you've been living?"

Jane: "Yes, I do. I feel lonely and out of place with the kids at school. I'd like to socialize more but I'm afraid. I never have any fun. All I do is worry about my grades and about food."

Mary: "I can understand some of Jane's feelings. Even though people think I'm really outgoing, actually I'm afraid that people won't like me. I feel like the only reason anyone likes me is because I look attractive."

Dr. Jones (to Mary): "What gives you that impression?"

Mary: "People are always complimenting me on my looks. No one notices the other things I do. When I'm around other people all I think about is food."

Dr. Jones (to Mary): "Do you see any connections between the fears you have around other people and your constant thoughts of food?"

Mary: "I notice that when I'm doing something I like, I don't think about food as much."

Teresa: "Well, I love gymnastics but after each meet I binge like crazy."

Dr. Jones (to Teresa): "When you compete, are you feeling anxious or fearful about anything?"

Teresa: "Well, I am terrified of losing. The only attention I get is from being a good athlete."

Dr. Jones: "It sounds like each of you is fearful of being rejected by your peers and family. It also sounds like you have high expectations of yourself. It might be helpful to consider how you can value yourself even when others don't value you and how you can have reasonable expectations of yourself."

Although the previous dialogue covers just a small sample of concerns that individuals with eating disorders express, it touches on several important components that combine to create dysfunctional eating attitudes and behaviors. Many eating-disordered individuals do not seek treatment until adulthood, yet most eating disorders begin during the stressful years of adolescence. Although most adolescents share some of the same concerns individuals with eating disorders feel, their concerns are not as extreme and do not dominate their lives. What begins as an attempt to control weight becomes transformed into a way of life that short-circuits normative development—physically, socially, and psychologically. By the time many are either brought to treatment or seek treatment for themselves, they lag behind their peers in development. It is crucial that treatment be implemented before the behavior patterns become too infused. A recognition of the early signs and symptoms of an eating disorder in vulnerable adolescents can be a critical part of successful therapeutic intervention.

Although anorexics and bulimics may be men, the majority of eating-disordered individuals are women; therefore, this chapter will address anorexia nervosa and bulimia nervosa as female disorders. The chapter will discuss relevant sociocultural factors that set the stage for vulnerable adolescents to respond to both internal and external stressors by developing an eating disorder. The discussion will detail signs and symptoms that can alert teachers, coaches, family, and friends that a peer or student may be progressing to an eating disorder, and will then present the current theories of causation of the disorders. The chapter will continue with a review of types of treatment for anorexia nervosa and bulimia nervosa that include various counseling approaches that have effectively interrupted the eating disorder cycle, and will conclude with a consideration of prevention programs that may be employed by individuals, schools, or communities to dissuade the continuing development of eating disorders.

Sociocultural Milieu

Why have eating disorders become so prevalent in our society? One answer can be found in the national obsession with thinness. Magazines, newspapers, television, and even the fashion industry flash the covert and overt message that one must have a svelte figure in order to be successful, desirable, or even acceptable. Conversely, the cultural milieu deprecates obesity to such an extent that obese individuals are stigmatized and shunned. Historically, when food was scarce, obesity became associated with the upper social classes. As food has become more available, obesity has become associated with lower social classes and is seen as socially and physically undesirable.

Wooley and Wooley (1979) believe that the pursuit of thinness has become a moral issue. They report numerous studies showing that individuals are enculturated with this prejudice during childhood. Thinner children tend to be liked more than children of average or heavier weight. Weight was found to be critical in the relationship between body image and self-concept. The thinner the girl, the more likely she was to report feeling attractive, popular, and successful academically. Obese children were described as being ugly, stupid, mean, sloppy, lazy, and dirty based on their size alone, and were avoided more than children who were severely handicapped. They were seen as responsible for their condition.

The desirability of thinness coupled with the fear of and stigma toward obesity has lead to an increased interest in dieting. Over the past 20 years, magazine articles on dieting have increased significantly (Garner, Garfinkel, Schwartz, & Thompson, 1980). Among adolescents and young women, dieting is more prevalent that not dieting (Polivy & Herman, 1987). Dieters may use appropriate weight control strategies, but several researchers (Klesges, Mizes, & Klesges, 1987) found that even in a normal population sample, individuals frequently risked their physical health to attain thinness. Inappropriate weight loss methods used included self-induced vomiting, laxatives, fasting, over-the-counter appetite suppressants, smoking, and caffeine. Despite the current national emphasis on health and fitness, the quest for thinness overrides concerns for good health.

Why are so many more women affected by eating disorders than men? The societal pressure to be thin seems to affect the majority of women in a negative way. Leon, Carroll, Chernyk, and Finn (1985) found body size dissatisfaction to be significantly greater for women than for men. Of the women surveyed, 79.9% desired a lower body weight, whereas of the men surveyed, 65.1% were satisfied with their present weight or had an ideal weight that was higher than their present weight. These findings were confirmed by Fallon and Rozin (1985). They found that women view themselves as significantly heavier than their ideal and what they believed men would find attractive. For men, there were no significant differences between current weight, ideal weight, and the weight they perceived to be attractive to women. Women were also more likely to weigh themselves and to diet more frequently than men.

How has a preference for thinner female bodies evolved? The thin standard seems to be associated with wider issues regarding the role of women in society. Historically, the thin standard is correlated in a negative and significant way to the proportion of professional working women and to the proportion of women graduating from college (Silverstein, Perdue, Peterson, Vogel, & Fantini, 1986). Curvaceous women are seen as less competent and less intelligent. More ample bodies seem to be associated with the traditional feminine role of wife and mother. During periods when it is important for women to be seen as competent and intelligent, the standard of attractiveness demands thinness. In fact, Silverstein et al. reported that as women's concerns with what others think of their intelligence increases, their thin standard becomes even thinner.

Within a relatively short period of time, mental health professionals have observed high numbers of women reporting eating disorders. Several authors (Anderson, 1985; Casper, 1983; & Russell, 1985) believe that the high prevalence of symptoms of eating disorders is due to pathoplasticity, that is, the tendency for psychiatric disorders to change in response to changes in fashion. Because of the current emphasis on slimness and the high level of stress women experience in conflicting roles, they express their neurotic symptoms that otherwise may have come out in a different way as an eating disorder. Women who are susceptible to these forces are those who have been strongly influenced by societal pressures, who are perfectionistic, and who hold a self-schema in which body weight is central (Striegel-Moore, McAvay, & Rodin, 1986). Other women at risk include those who are biologically heavier, women who come from families that overemphasize appearance, and women who are depressed and ignore their own needs in preference to the needs of others.

Adolescence As a High-Risk Period for the Development of Eating Disorders

During adolescence several developmental tasks that link behavior with internal and external forces must be accomplished for satisfactory growth to occur. Developmental tasks are determined by the interplay of biological, cultural, and psychological forces. Strober and Yager (1985) listed four adolescent tasks necessary for optimal physical and psychological health: (1) adolescents need to establish peer attachments as part of the initiation of physical and sexual maturity; (2) they must progress from concrete to more abstract thinking, which is reflected in their ability to separate self from environment; (they develop a sense of the future by being able to separate from the here and now); (3) they must develop autonomy as expressed by shifting away from parental values and finding gratification outside of the home; and (4) subsequently, they must emerge with an identity and stable self-structure and a commitment to a system of personal beliefs.

The process of accomplishing developmental tasks includes discontinuities that are predictive of psychological health. Previously compliant children may become complaining adolescents. Their expressions of self-confidence may give way to expressions of self-doubt. As they express their desire for independence, they vent more feelings of dependency. Their tempers may become more explosive and unpredictable, yet such roller-coaster emotions are a normal and necessary part of adolescent growth. Eating-disordered adolescents fear such emotional upheavals and strive to counteract them by denial of feelings or increased efforts to be controlled and contained.

Physical maturation is another developmental factor affecting adolescents' vulnerability to eating disorders. Streigel-Moore et al. (1986) believe that the normal maturation process is a risk factor for girls. Physical maturity brings boys closer to the attainment of their ideal, tall, muscular look, but physical maturity in girls leads them to concerns about weight. Pubescent girls gain twice as much fat as boys. Adolescent girls list weight as their primary appearance concern, thus diets become a major focus. Adolescent girls seem to be more sensitive to evaluations by others and subsequently more sensitive to social demands. They receive a strong social message that beauty and thinness are important attainments. The authors report several studies showing that heterosexual relationships are more problematic for girls than boys, yet girls rank popularity as their first priority, even above independence or competence. In adolescence, when establishing heterosexual relationships is a primary task, thinness becomes synonymous with attractiveness and attractiveness synonymous with popularity.

Researchers have correlated several other factors that make some women more susceptible to developing eating disorders. Gross and Rosen (1988) found that depression, poor body image, and social anxiety predict eating disorders. Kiemle, Slade, and Dewey (1987) reported that general dissatisfaction, loss of control, perfectionism, high food avoidance, and preoccupation with weight were eating disorder correlates. Streigel-Moore et al. (1986) listed five components corresponding to eating disorder vulnerability: (1) women who are perfectionistic; (2) women who incorporate a belief system in which weight is central; (3) women whose families have high expectations and overemphasize appearance; (4) women who have a biological tendency to be heavier than they desire; and (5) depressed women with low self-esteem. Kaplan, Busner, and Pollack (1988) found that lack of satisfaction with appearance was associated with depression regardless of actual weight. Women who believed they were of normal weight were less depressed. Frequent dieting is invariably a precursor to the development of an eating disorder.

A developmental lag in several areas can be the disruptive consequence of an eating disorder. The greatest factor hampering normal adolescent development for both bulimics and anorexics is their social isolation. Social distancing creates poor peer relations, leaving little chance for discovering new ways of interacting. Peer groups are vital in the transition from adolescence to adulthood. They provide necessary links from the family to occupational and other nonfamilial spheres. Social impairment may cause problems at work and school as well as family disruption, and may exacerbate depression and anxiety, possibly leading to suicide attempts.

When an eating disorder is used as a coping mechanism, it increases both depression and stress and inhibits the learning of more appropriate coping skills. For example, female purgers are more likely than nonpurgers to abuse alcohol. They use alcohol as a stress reducer (Killen, Taylor, Telch, Saylor, Maron, & Robinson, 1987). The interpersonal deficits and lack of coping skills that result from eating disorders leave the adolescent unprepared for the later demands of adulthood.

Diagnostic Criteria

Anorexia nervosa is a syndrome characterized by the denial of hunger, a fear of fat, and diligent pursuit of thinness. Anorexia nervosa literally means "nervous lack of appetite;" however, a loss of appetite does not generally occur until late in the starvation process. The essential features of anorexia nervosa, commonly referred to as anorexia, as established by the American Psychiatric Association (1987) are:

A. Refusal to maintain body weight over a minimal normal weight for age and height, e.g., weight loss leading to maintenance of body weight 15% below that expected; or failure to make expected weight gain during period of growth, leading to body weight 15% below that expected.

B. Intense fear of gaining weight or becoming fat, even though underweight.

C. Disturbance in the way in which one's body weight, size, or shape is experienced, e.g., the person claims to "feel fat" even when emaciated, believes that one area of the body is "too fat" even when obviously underweight.

D. In females, absence of at least three consecutive menstrual cycles when otherwise expected to occur (primary or secondary

> amenorrhea). (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration.) (p. 67)

Bulimia is the term most commonly used to refer to an abnormal weight control method that is characterized by episodic binge eating followed by a purging activity. The word bulimia literally means "ox hunger" or an insatiable craving for food, so the term bulimia nervosa more appropriately describes the binge/purge eating behavior. In 1987, the American Psychiatric Association amended the name of the syndrome of bulimia to bulimia nervosa. The revised criteria for diagnosing bulimia nervosa are:

> A. Recurrent episodes of binge eating with a rapid consumption of a large amount of food in a discrete period of time.
> B. A feeling of lack of control over eating behavior during eating binges.
> C. The person regularly engages in either self-induced vomiting, the use of laxatives or diuretics, strict dieting or fasting, or vigorous exercise in order to prevent weight gain.
> D. A minimum average of two binge eating episodes a week for at least three months.
> E. Persistent over-concern with body shape and weight. (pp. 68–69)

Signs, Symptoms, and Theories of Causation

Anorexia Nervosa

Ninety-five percent of anorexics are female. The symptoms most often begin at either age 14 or age 18. It is currently estimated that between .6% and 1% of young women will suffer from anorexia. A first symptom is often a change in personality characterized by mood swings and social distancing. As a noticeable weight loss occurs, the anorexic no longer eats with family or friends but is always ready with numerous excuses such as "I already ate" or "I have other lunch or dinner plans." As the body weight drops lower, the anorexic is always cold and will often wear winter clothes near the summer months. The anorexic becomes more isolated as the disease progresses. The schedule of obsessive exercise and restraint of eating becomes a full-time job, leaving little or no time or energy for other activities. Sleep problems arise and by this time, menstruation will have ceased and the anorexic may be losing scalp hair. As the anorexic becomes more emaciated looking, peers may label her anorexic, which leads her to other manipulative behaviors. The anorexic feels angry toward others who chastise her or attempt to get her to eat, and she lies and deceives others about her eating behaviors.

As the self-imposed starvation continues, many of the recognizable symptoms include poor concentration, concrete thinking, rigidity, social withdrawal, anxiety, depression, and emotional lability (Garner & Bemis, 1982). In summary, the general symptoms of anorexia include low self-esteem, lack of self-confidence, inability to make decisions, perfectionism, dependency on others, compulsive overachievement, isolation, poor social relations, and emotional immaturity. (See Table 1 for a detailed list of the signs and symptoms.)

Environmental stressors, depression, and puberty are three common precipitating factors in the dynamics of anorexia that correspond with dieting. The anorexic begins her pursuit of thinness with dieting like many typical adolescents. Eventually, however, losing weight represents virtue, control, and mastery. Often the anorexic may have been slightly overweight before her self-imposed starvation. Environmental stressors such as family illness, the divorce of parents, or relocating cause anxieties. The potential anorexic reduces anxiety by dieting. Major life changes may also include losses such as the death of a loved one or a breakup with a boyfriend. Such losses may lead to depression, a possible increase in weight, and the beginning of a dieting obsession. Dieting is often begun in an effort to dissuade the growth of the breasts and hips during puberty.

The etiology of anorexia nervosa is unknown, but several theories have been formulated to explain the causation of this disorder. From a psychological view, it is postulated that the illness may act as a defense against anxiety regarding guilt over impulses. The anorexic feels virtuous and in control when she has the willpower to overcome her hunger instinct. The illness may serve to attract attention from her parents. When faced with increased stress, the anorexic's ability to control her weight loss provides a sense of stability. Bruch (1982) suggested that certain people are predisposed to anorexia because of basic ego deficits.

Other etiological viewpoints include developmental, sociocultural and learning, family, and biological theories. Developmental theory postulates that anorexia [illegible] a coping response to feeling overwhelmed by maturational crises. Anorexics may fear and wish to avoid anxiety-producing adult activities and relationships. Socioculturally, thinness is the standard of beauty that provides initial positive reinforcement for the anorexics' initial weight loss. Others may compliment them and ask for their dieting success secrets. Later, as they reach an emaciated state, attention and concern from parents and friends may be positively reinforcing. Positive self-reinforcement for self-control and weight loss may

TABLE 1

Signs and Symptoms of Anorexia Nervosa

Psychological

- Poor self-esteem
- Suicidal thoughts
- Distorted body image
- Compliance
- Perfectionism
- Rigidity
- Fear of food and weight gain
- Depression
- Denial of problem
- Overachieving
- Anxiety
- Feelings of control over body
- Apathy
- Mood swings

Behavioral

- Extreme physical activity
- Fatigue
- Fights with family
- Self-isolation from family and friends
- Compulsive exercise
- Overuse of laxatives or diuretics
- Eating alone
- Overeating (may cook and control family's eating)
- Progressive preoccupation with food and eating
- Sleep disturbances

Physical

- Excessive weight loss—15% or more of total body weight
- Malnutrition
- Sensitivity to Cold
- Diminished capacity to think
- Cardiac arrest
- Lassitude (fatigue)
- Cavities and gum disease
- Growth of facial and body hair (lanugo)
- Hair, skin, and nail problems
- Misperception of hunger, satiety, and other bodily sensations
- Electrolyte imbalance (weakness)
- Joint pain (difficulty walking and sitting)

perpetuate the behavior. As the anorexic develops the fear of food and fat, negative reinforcement of avoidance of feared situations contributes to the maintenance of the system (Garner & Bemis, 1982). Family theories deduce that the identified patient is an expression of an ill family. Families are generally studied after the diagnosis of the disorder, so the concurrent family dynamics may not necessarily reflect the premorbid conditions. Biologically, anorexia can be explained as being a hypothalamic disorder. Many researchers conclude that the anorexia syndrome is a consequence of the interaction of individual, familial, and cultural forces. Extensive research is still needed for the evidence of any one theory to be conclusive.

Bulimia Nervosa

Ninety percent of bulimics are female. The American Psychiatric Association (1987) lists the prevalence and sex ratios at 4.5% for women and .4% for men. Crowther, Post, and Zaynor (1985) found the incidence of bulimia to be as high as 5% in high school students. Self-report surveys of nonclinical college women engaging in binge eating range from 13% to 67% (Halmi, Falk, & Schwartz, 1981). The onset of bulimia generally occurs in late adolescence or early adulthood.

The initial symptoms of bulimia are occasional binge eating in response to feelings of deprivation due to strict dieting. After attempting to maintain a rigid diet for long periods of time, the bulimic will begin binging more frequently. Eventually, the fear of gaining weight leads the bulimic to engage in some form of purging. The average delay between onset of binging behavior and onset of purging behavior is 1 year. Once purging behavior begins, the frequency of binging increases. What began as an occasional weight loss technique becomes a daily occurrence. Most bulimics attempt to avoid food during the day. This avoidance causes mounting hunger, which ultimately results in a binge. The average bulimic binges on a daily basis at home in the later afternoon and early evening. As the disorder progresses, many do not eat regular meals at all and alternate between restricting or binging. They often plan their schedules around times when they can binge and avoid activities that prevent them from binging. They also avoid eating situations where they are unable to purge. Due to fluctuating blood sugar levels, bulimic women have difficulty concentrating and have wide mood swings.

The general symptoms for bulimia include low self-esteem, sensitivity to depression, poor impulse control, lack of assertiveness, cognitive distortions, poor body image, and the use of binges to deal with stress. (See Table 2 for a detailed list of the signs and symptoms.)

The onset of bulimic symptoms is most often associated with a period of voluntary dieting, difficulty in handling negative emotions, and traumatic life events such as a loss or transition. Developmentally, bulimics have difficulty dealing with transitions and changes. Common major life events affecting bulimics are interpersonal losses such as breaking up with a boyfriend or the death of a parent, and transitional events such as moving away from home to a university or changing a job. Strober (1984) found that stressful events most often reported by bulimics included estrangement from friends, marital discord, conflict with parents, serious illness in a parent or self, involvement with drugs,

TABLE 2

Signs and Symptoms of Bulimia Nervosa

Psychological

- Low self-esteem
- Embarrassment
- Anxiety
- Depression
- Mood swings
- Feeling that self-worth depends on low weight
- Dependency on others for approval
- Constant concern with weight and body image
- Fear of binging/eating and getting out of control
- Suicidal tendencies/attempts

Behavioral

- Poor impulse control
- Self-indulgent behvior
- Eating alone
- Dishonesty—lying
- Stealing food/money
- Drug and alcohol abuse
- Experimentation with vomiting, laxatives, and diuretics
- Preoccupation with food and eating
- Elimination of normal activities
- Social isolation/distancing from family and friends
- Binging on high carbohydrate foods
- Laxative and diuretic abuse

Physical

- Normal weight
- Anemia
- Tooth damage
- Chronic sore throat
- Electrolyte imbalance
- Dehydration
- Irregular heart rhythms
- Tiredness, apathy, irritability
- Gastrointestinal disorders
- Difficulties in breathing/swallowing
- Hypokalemia (abnormally low potassium concentration)
- Generally ill health/constant physical problems
- Possible rupture of heart or esophagus/peritonitis

increased absence of father from the home, and disillusionment with school.

Many theories of etiology have been postulated to explain the pathogenesis of the bulimic syndrome. A theory of etiology developed by Johnson and Maddi (1986) includes pscyhological, biological, sociocultural, and family factors. This model must be considered as a tentative explanation of the syndrome because empirical validation is still needed.

From a psychological perspective, the bulimic has a vulnerable personality with affective instability. This instability is evidenced by impulsive behaviors and low frustration tolerance, low moods, high anxiety, and highly variable moods. The bulimic has low self-esteem, is self-critical and interpersonally sensitive, has a high need for achievement, feels ineffective, and has a high level of dissatisfaction for her body. From a biological viewpoint, the bulimic may have an increased risk for depression that is genetically transmitted. Several family studies (Hudson, Laffer, & Pope, 1982) report a high prevalence (48%) of familial affective disorder in the first-degree relatives of bulimic patients, similar in prevalence to families of patients with affective disorder. Although the etiology of depressive symptoms remains unclear, it does seem that bulimics have a high risk factor for developing an affective disorder. Bulimics may also have a biologically higher "normal" weight or set point. Their set point may be aesthetically too high for them but physiologically normal. Such individuals may begin to diet in an effort to control their body dissatisfaction. The dieting then leaves them chronically hungry, setting the stage for binging.

Sociocultural factors relevant to causation include both changing sex-role expectations and the emphasis on appearance. Because cultural norms are in transition, women face ambiguous and contradictory role expectations. The new wider range of possible role choices may be overwhelming for field-dependent individuals who lack internal structure. The bulimic may experience much anxiety in reaction to shifting role expectations in light of the high demand for achievement from her family. Combined with the feminist movement, the pursuit of thinness has emerged as one way women can compete and demonstrate self-control. Thinness is highly valued, and pursuing it becomes one concrete activity through which women can compete.

Family factors include a familial environment often characterized as disengaged, chaotic, and highly conflicted with a high degree of stress. Family members use indirect and contradictory communication patterns. The families have high achievement expectations yet have limited intellectual and recreational orientations. In summary, these etiological theories generally agree that individual personality deficits combined with family and cultural factors serve to direct the individual's anxiety onto her body.

Bulimia and Anorexia Compared

Bulimia and anorexia have several similarities but also important differences. The disorders may be viewed on a continuum with overlapping symptoms along the spectrum. Not all individuals experience every symptom nor do the symptoms progress in exactly the same order for every bulimic and anorexic. Shared features of the two disorders include a fear of fatness, a preoccupation with weight and food, and the use of weight and food to cope with emotions. There are several differences between anorexics and bulimics. Anorexics tend to be more introverted and less sexually active than bulimics. The amount of weight lost is usually much greater for anorexics. Whereas anorexics have few behavioral abnormalities, bulimics often engage in impulse behaviors such as stealing and drug and alcohol abuse. The restrictive eating behavior of anorexics is usually a source of pride and self-esteem. On the other hand, bulimics' eating behavior is often ego dystonic and a source of stress and shame. When an anorexic becomes bulimic, she will manifest both anorexic and bulimic symptoms; however, treatment goals and the recovery process are comparable for both eating disorders.

Treatment Applications

Anorexia Nervosa

Impediments to Treatment

Anorexics generally do not recognize that their disorder is dysfunctional and is disrupting their lives. They have derived feelings of competence and uniqueness from being able to diet successfully and maintain control despite the intense hunger they often feel. Therapy is viewed as a threat to their self-esteem. They fear being robbed of their specialness (Anderson, 1985) and being asked to relinquish their dieting behavior, which has become a way of life that solves life's complexities. Often their families share the anorexics' high regard for the value of thinness and subtly ignore the severity of their childrens' problem.

Anorexic families frequently present a healthy image to the outside world and discourage much intimate contact with others, viewing such contact as an invasion of their autonomy and closeness between family members. They may view therapy or any expression of feelings as a sign of weakness, so they avoid treatment. Some families avoid help because they fear it will only escalate the existing family problems. Consequently, treatment is often delayed to the point where normal development has been impaired.

Types of Treatment

Medical consultation and assessment. A medical assessment of the anorexic's status is essential because of the severe medical problems related to starvation and malnutrition. The individuals' vital signs are often lowered including blood pressure, heart rate, body temperature, and respiration rate (Anderson, 1985). A physical exam and laboratory evaluation are necessary to confirm that no other illness has caused the weight loss and to assess the severity of the malnutrition. At a minimum, the individual should have a test battery that includes a blood test, electrolyte test, liver and thyroid functioning tests, an electrocardiogram, and a chest X ray (Brotman, Rigotti, & Herzog, 1985). In severly emaciated individuals, weight and vital signs need to be monitored regularly.

Nutritional rehabilitation. Nutritional rehabilitation is the first step in any treatment program whether done alone or on an inpatient or outpatient basis. Starvation affects cognitive and affective functioning in addition to physical capacities. Mental efficiency is decreased. Driven activity may disguise low mood and intrusive thoughts of food. The individual may appear somewhat suspicious and fearful. Garner (1985) stated:

> The failure to differentiate primary psychotherapy from the secondary elaboration of starvation symptoms not only leads to a faulty conceptualization of dynamic issues but also disregards the observation that psychological themes at presentation may share little with those which emerge at weight restoration. (p. 703)

Although the restoration of body weight may seem intrusive to the individual, it is necessary for the perservation of thinking and to increase abstract thought. In addition, as weight increases, the resultant change in hormonal balance tends to increase affective reactions that are not apparent during the starvation state.

Although the method of weight restoration used depends on the severity of the illness, it is best to use the least restrictive approach (Neuman & Halvorson, 1983). If the illness is in its early stages and hospitalization is not needed, consultation with a dietitian is helpful. The individual should be provided didactic material related to starvation, weight regulation, and nutrition. Then a realistic target weight is established. Some programs set the minimum target weight as the weight at which menses return plus five pounds. The weight selected should be consistent with the individual's weight history. Weight must be monitored regularly with attention to a weight loss that may require hospitalization. Often the initial goal is weight maintenance, then after a week, a weight gain of one to two pounds per week is advised (Strober & Yager, 1985). In outpatient treatment, weight gains may be flexible but must be sustained. The individual also is helped with meal planning. The outpatient therapist or dietitian should help minimize food choices for the individual. The therapist may have to focus on details of food intake as part of the therapy process. Eventually feared foods will have to be incorporated into the diet.

Food is presented to the individual as prescribed medication and meals are supervised. Most inpatient programs (Anderson, 1985; Strober & Yager, 1985) encourage patients to regain weight by eating normal meals on a regular basis. This process of relearning how to eat in a normal way is time-consuming but important to overcoming the fear of food. The individual must be reassured she will not get fat and weight gain will not be excessive or rapid.

Inpatient treatment. Several indicators point to the need for inpatient treatment. Individuals who are at a significantly low weight (25% below normal weight) do not do well in outpatient treatment because chronic hunger interferes with mental functioning. As hunger increases, so do intrusive thoughts of food and anxiety caused by the urge to eat. Another indicator for hospitalization is metabolic abnormalities such as low levels of serum potassium caused by purging. Low mood is an indicator of inpatient care, especially when the individual has suicidal ideations or intents. Individuals who have not improved after much outpatient treatment and individuals whose families are demoralized and are no longer willing to help are also appropriate for inpatient treatment. If at all possible, the anorexic individual should be involved in making the decision for hospital admittance. Sometimes admission needs to be negotiated between the patient and the family (Powers & Powers, 1984) and sometimes, if the individual is very ill and refuses treatment, a court order may be necessary to prevent self-harm (Anderson, 1985).

A highly structured environment at the beginning of treatment seems to be helpful. Initially, such a structure helps to decrease anxiety and the fear of losing control. Inpatient programs frequently use contingency management programs as well as a standardized behavioral contract for weight restoration (Vandereycken, 1987). The individual who gains weight is positively reinforced by receiving privileges and increased freedom whereas the individual who does not gain weight is denied access to the reinforcing activities. An emphasis on immediate weight gain may be necessary for severely emaciated or resistant individuals. Although attention to weight does produce positive short-term results, the long-term results may be further interpersonal or intrapsychic difficulties. Garner (1985) warned that behavior modification principles must be used with a focus on the individual. Weight gain and eating should not be the exclusive focus of attention.

Inpatient programs generally include multiple forms of treatment including individual, group, and family therapy. Often they also include other hospital therapies such as art and movement therapy, leisure counseling, and assertiveness and relaxation training. Strober and Yager

(1985) and Vandereycken (1987) believe that anorexic adolescents should be exposed to nonanorexic patients. They agree that anorexics can use others as models to learn coping skills. It is extremely important to prepare the individual for discharge and provide adequate aftercare to prevent relapse.

Outpatient treatment. Outpatient treatment is suitable for individuals who express motivation to change, have some insight, and are able to tolerate some weight gain. Individuals who are not more than 20% below ideal weight are also good candidates. They should not be severely depressed and should be able to maintain some peer relationships (Strober & Yager, 1985). Also, individuals who have been discharged from inpatient treatment require outpatient treatment.

The goal for younger patients who have not been chronically ill is to achieve normal weight and to reintegrate into their normal life. Outpatient treatment follows the same principles as inpatient treatment except that the stages of nutritional rehabilitation and psychotherapy overlap more. Psychotherapy begins sooner because the individual is not as physically compromised as an inpatient counterpart. Although a meal plan may be compiled by a nutritionist, often the therapist monitors progress in weight gain and eating. Therapy must include a focus on eating patterns and their relation to emotions and behavior. Gradually the patient assumes full control of choices regarding food, exercise, and weight. In outpatient treatment, it is important to help the individual structure free time. It is best to have a moderately paced and well-structured day.

Pharmacological treatment. Several medications have been utilized in the treatment of anorexia. Most have yielded disappointing results (Brotman et al., 1985). Because starvation affects mood, several authors do not prescribe antidepressants until the individual is within normal weight and symptoms of depression persist (Anderson, 1985; Garner, 1985). The most commonly used antidepressant medications for anorexia are the tricyclics and the monoamine oxidase inhibitors. Anti-anxiety medications are also used to reduce anticipatory anxiety prior to meals and can be useful for sleep disturbances. The abuse potential in restricting anorexics tends to be low, so anti-anxiety medication can be used with greater safety than with bulimics. Even when medication is helpful, it should not be the sole form of treatment because psychological and developmental issues still need attention.

Useful Counseling Approaches

Individual therapy. Individual therapy at first should be generally supportive to help the patient cope with interpersonal and intrapsychic difficulties. Individual therapy requires an especially trusting relationship between the therapist and patient because the patient wants to retain the symptoms. The goal of therapy is to decrease the symptoms while increasing personal growth. Insight-oriented therapy helps the anorexic in recognizing and differentiating internal physical and emotional states and in acknowledging and expressing affect. The individual is encouraged to take risks, increase a tolerance for uncertainty, and focus on issues of autonomy. The fear of losing control and the meaning of low weight must be explored.

Cognitive approaches are used to help challenge irrational thoughts regarding food and self. Therapy must correct these thoughts and provide alternative ways of viewing the self and the world. The anorexic must also develop a more accurate body image and so must challenge perceptual distortions. Behavioral approaches are used to increase coping skills such as assertiveness, relaxation, and social skills.

Family counseling. Anorexia can become a focal point for family interactions (Sargent, Liebman, & Silver, 1985). The anorexic is affected by the family and the family is affected by the eating disorder. Several researchers (Anderson, 1985; Sargent et al., 1985; & Strober & Yager, 1985) believe that family therapy is a necessary part of treatment unless the family is extremely hostile or intrusive.

The goals of family counseling are to help each member deal with concerns about the eating disorder problem, become more autonomous, resolve conflict, and encourage appropriate coalitions between the family subsystems. The structural family therapists propose that anorexic family traits include enmeshment, overprotection, rigidity, lack of conflict resolution, and involvement of a child in parental conflict. The anorexic family has not promoted the autonomy of its members. The family must be encouraged to reinforce the independent action of its members and to encourage the anorexic to build salient connections with her peer group instead of being bound to the family. The specific goals in therapy may depend on the stage of the family life cycle. If the anorexic is very young and will be living at home for a long time, treatment strategy will be different from that for an older child.

Vandereycken (1987) does not assume that all eating disordered families are dysfunctional, but does agree with other researchers that the family is in crisis and could benefit from intervention. Families must be viewed as treatment resources and not treatment adversaries. There may be typical types of families, but there is also much diversity. The family therapist needs to assess patterns in the family that may be sustaining the anorectic behavior.

Group therapy. Group therapy is an important adjunct to individual and family therapy for anorexic individuals. It provides an opportunity to work on peer relationships, to explore feelings about family, and to increase self-awareness and self-expression. Reestablishing close peer relationships is integral in the treatment of anorexia. Group feedback greatly affects the anorexic's perceptual distortions (Inbody & Ellis, 1985) and cognitive distortions (Strober & Yager, 1985). Group therapy is often not used with anorectic individuals because their personality dynamics tend to make them poor candidates for group therapy. They are usually withdrawn, rigid, egocentric, anxious, and have difficulty with identifying and expressing feelings. Hall (1985) stated that members must be carefully selected. She suggests that the two counterindicators for group inclusion are denial of the illness and need for medical management of starvation symptoms. The group goal must be safe and allow individual attention to each member's feelings. The therapist often must be very active and provide much structure in the beginning stage of the group. Groups are an ideal environment for anorexics to explore lack of assertiveness, fear of displeasing others, and feelings of anger and isolation.

Bulimia Nervosa

Impediments to Treatment

In contrast to anorexic individuals, bulimic individuals generally do recognize that their eating habits are abnormal and have a disruptive influence on their lives. Although they may want to change some of their behaviors, they are also extremely fearful of giving them up. Most bulimics believe that they can maintain a desirable weight only by binging and purging. If they consume normal amounts of food and do not purge, they fear they will be overweight. Many associate being overweight with social isolation and rejection by peers and family. Because they feel their only choice is to be either bulimic or overweight, many choose to remain bulimic because they can retain a socially acceptable outward appearance that connotes control. In addition, some bulimic individuals do recognize that the bulimic cycle helps contain and regulate their affective reactions. Because many do not have adequate coping skills, they fear living without the anxiety reduction that binging and purging afford.

Another impediment to treatment is the socially undesirable and repulsive nature of the behavior itself. Many bulimics fear rejection if their behavior were to be known, so they keep their behavior in the closet. These women are extremely sensitive to the rejection of others and fear being perceived as less than capable. Again, as in the case of anorexia, treatment often is not sought until the behavior has been occurring for some time.

Types of Treatment

Studies on the treatment of bulimia have been primarily undertaken only within the last decade; therefore, treatment conclusions are still rather tentative. Currently, however, a study of treatments by Laessle, Zoettl, and Pirke (1987) found that overall the average bulimic patient after treatment was better than 83% of the patients prior to treatment. These authors concluded that psychotherapy, especially when combined with dietary management, was superior to drug therapy.

Medical consultation and assessment. Medical complications can and do arise in the treatment of bulimia. The most predominant danger is electrolyte imbalance due to purging by vomiting or abusing laxatives and diuretics. Because electrolyte imbalances can be fatal, it is imperative that a medical assessment be done by a medical doctor prior to counseling. A medical evaluation includes an assessment of gastrointestinal symptoms, weight, and hypokalemia and its medical consequences. If the individual is using laxatives to purge, it is advisable to have a physician monitor the individual to decrease laxative dependency. Electrolytes should also be monitored during treatment.

Nutritional rehabilitation. Normalization of eating is usually given top priority in most treatment programs. Until a normal intake is reestablished, the bulimic will be compelled to binge due to biological cravings. Many bulimics maintain weight goals that are far below their own biological set point (Garner, 1985). Their desire for a low body weight causes them to constantly fight their own biology. Many treatment programs first help individuals determine an appropriate weight goal given their prior individual and family history. Many suggest nutritional counseling and meal planning with the help of a nutritionist (Rock & Yager, 1987). Some programs teach appropriate eating habits and the appropriate use of aerobic exercise to regulate energy balance. Most programs (Fairburn, 1985; Lacey, 1983) encourage individuals to introduce forbidden foods in their diet gradually. Many bulimics have eliminated whole categories of food, which also enhances their cravings for these forbidden foods. Only after an appropriate weight is reestablished and a full range of food is restored will bulimic individuals be able to focus on psychological reasons for binging and purging. Purely psychodynamic treatment approaches that do not attend to changes in eating behavior have not proven effective (Garner, 1985).

Inpatient treatment. Inpatient treatment generally is not the treatment of choice for bulimic women (Anderson, 1985; Russell, 1979;

Yager, 1985). These authors suggest that inpatient treatment should be considered only if medical complications exist that require treatment such as low body weight or electrolyte imbalances, if the patient is suicidal, of if outpatient therapy has failed and the patient's health is suffering. Anderson believes that inpatient therapy is not usually therapeutic for treating impulse disorders.

Many bulimic women are able to stop the bulimic cycle when hospitalized because they are under constant supervision and are insulated from the stresses in their daily lives. When discharged and left to their own devices, they are not able to continue their progress. Anderson (1985) stated that bulimics have even more difficulty than anorexics in making the transition from the hospital to their home environment. Bulimic inpatient treatment is usually not as comprehensive as anorexic inpatient treatment. Bulimic treatment includes initial normalization of eating, individual and group therapy, and often family therapy. When hospitalization is utilized, attention must be given to follow-up care because relapse is common.

Outpatient treatment. Initially, outpatient treatments focused on only the symptoms of binging and purging. Most researchers now believe that treatment needs to be multifaceted and attention needs to focus on the bulimic symptoms as well as other coexisting deficits (Orleans & Barnett, 1984). Behaviorists suggest that a complete functional analysis of the antecedents and consequences of bulimic behavior must be made before treatment is implemented. A complete functional analysis provides many points of intervention. Loro (1984) specified four areas of treatment intervention: cognitive, behavioral, emotional, and interpersonal. Among cognitive problems he listed lack of knowledge regarding food, distorted body image, and dichotomous thinking styles. Behavior problems include irregular eating and extreme dieting. Emotional problems involve a poorly developed capacity to define and express feelings effectively, including a confusion between negative feeling states and hunger. Interpersonal problems include nonassertiveness, isolation, counterdependency, and rebelliousness. Many interventions have been used successfully to treat these problem areas. They include cognitive restructuring, anxiety management, self-control techniques including self-monitoring, emotional expressiveness training, anger control, assertiveness, social skills training, and paradoxical techniques. Outpatient treatment programs run the gamut from highly structured, intensive abstinence-based programs (Pyle, Mitchell, Eckert, Hatsukami, & Goff, 1984) to weekend retreats (Bohanske & Lemburg, 1985).

Pharmacological treatment. Several researchers believe that bulimia may be a symptom of or be related to a primary affective disorder (Pope, Hudson, & Jonas, 1984). As a result, antidepressant medications have been used to treat bulimics. They include monoamine oxidase inhibitors (MAOIs) and tricyclic and tetracyclic antidepressants. Some researchers have reported that tricyclics are well tolerated by adolescents and that MAOIs are well tolerated by older, more chronic individuals with symptoms of atypical depression. Treatment studies utilizing antidepressant medications have found equivocal results (Garner, 1985). Mitchell (1988) stated that the effectiveness of antidepressants has not been definitively demonstrated either in the short run or the long run. Studies show high dropout rates and high relapse rates after medication has been discontinued. Walsh (1988) reported that antidepressants are superior to placebos and that a significant fraction of bulimics do respond to medications; however, it is not known how many who initially respond will continue to respond if they remain on medication and how many will relapse if medication is discontinued. Researchers do not know how to distinguish responders from nonresponders because some women who are severely depressed are not helped whereas some who seem to be mildly depressed may be helped. Researchers also do not know whether antidepressants affect an underlying depression or affect another mechanism of action.

Garner (1985) suggested caution in the use of medications. He believes the treatment should sequence from the least potentially harmful or intrusive to that posing greater risks. A trial of psychotherapy would seem to be less intrusive than medication and should be tried first. As with anorexia, he also suggested that because depression may be secondary to starvation, severe dieting, and electrolyte imbalance, it may be more appropriate to normalize weight and eating patterns prior to antidepressant therapy. He stated that the use of antidepressants results in many negatives including poor compliance, side effects, and risk of abuse. Walsh (1988) recommended that patients who have failed to respond to psychotherapy are good candidates for antidepressant treatment and Mitchell (1988) recommended medication where bulimia occurs secondarily to a depressive disorder. Many advocates of antidepressant medication also support the use of psychotherapy in addition to antidepressant therapy because ignoring psychosocial factors and attitudes about eating and body shape is counterproductive.

Useful Counseling Approaches

A wide variety of interventions have been utilized in the treatment of bulimia. Each method has received some support in the literature, but it is premature to state that any one type of treatment has proven efficacy over another (Yager, 1985). Treatments have been used with individuals, families, and groups.

Individual therapy. Individual treatments can be tailored to meet the idiosyncratic needs of the client and may be necessary with individuals who would not benefit from a group approach. Individual treatment generally includes some education regarding weight and eating behavior. A behavior focus may utilize self-monitoring to increase awareness of patterns and the teaching of alternative coping skills including relaxation and assertiveness. Bulimic individuals have cognitive distortions that not only affect their eating behavior but also their self-image and other attitudes. Cognitive restructuring is utilized to decrease such distortions (Garner, 1986). The counselor can not only help to challenge reasoning errors such as dichotomous thinking, personalization, and overgeneralization but also can challenge the individual's underlying assumptions. An underlying assumption might be that weight and shape are a valid frame of reference for judging one's self-worth. Individuals learn to recognize connections between their dysfunctional thoughts, behaviors, and feelings. They are taught to substitute more realistic interpretations. Individual therapy also focuses on insight and affective growth. Individuals are helped to cope with affect, increase their toleration of dysphoria, and work on unresolved or current grief and anger issues.

Family counseling. Although some researchers view family therapy as an essential part of treatment, especially with younger individuals, others view family therapy as one possible component in a multidimensional treatment program (Vandereycken, 1987). Although family therapy is not always required, it is necessary to maintain a family-oriented approach. This approach allows an awareness of the family system and the ways in which the eating disorder of an individual is affected by and affects the family system. Not all bulimic families are dysfunctional but they are in crisis (Vandereycken). Bulimic families vary, but several structural family therapists like Minuchin describe them as having the common traits of enmeshment, lack of conflict resolution, overprotection, rigidity, and involvement of the child in unresolved marital conflict. Schwartz, Barrett, and Saba (1985) also added that bulimic families are isolated, unduly conscious of appearances, and attach a special meaning to food and eating. White (1984) stated that overinvolvement of the family influences the bulimic member to suppress normal adolescent tendencies toward autonomy and independence. Bulimics often are fearful of displeasing their parents and relying on their own judgment.

Following this conception of family dynamics, the goals of family therapy are to strengthen boundaries between the various subsystems in the family in order to facilitate individuation of family members. Family members are helped to negotiate more appropriate behavior and communication patterns and rules between members. The bulimic member needs to be helped to take more direct control of significant relationships and decision making.

Group counseling. Group counseling has been increasingly utilized as an alternate or adjunct to individual therapy. It is cost-effective and can be therapeutically advantageous. Bulimic individuals are often isolated, so groups can provide needed support to help individuals cope with their feelings of shame, guilt, and fear (Stuber & Strober, 1987). Although peer support is helpful for all bulimic individuals, it is especially effective with adolescents to challenge the unhealthy sociocultural pressures that adolescents face regarding diets and thinness.

Groups are particularly effective to use in combating body image distortion. When individuals see how others distort, they can more readily understand their own distortions (Inbody & Ellis, 1985). Groups provide an opportunity for modeling new behaviors. Members can learn to take risks and attempt to use new behaviors within the safety of the group. They can risk sharing their feelings or being assertive. When group members are at similar developmental stages, the issues of identity development, sexuality, and familial conflicts can be readily explored.

The first group treatment for bulimics was done by Boskind-Lodahl and White in 1978. Since that time, both short-term and long-term groups have been used. Most of the short-term groups in the literature follow a structured format. In the first phase of treatment, didactic information and normalization of eating are stressed as is developing awareness of the connections between thoughts and feelings and eating. Later, cognitive restructuring, identification and expression of feeling, and goal setting are used. Members also focus on developing problem-solving and coping strategies including relaxation and assertiveness skills. Short-term groups can be effective (Johnson, Connors, & Stuckey, 1983; Wolchik, Weiss, & Katzman, 1986) and are especially appropriate for individuals who do not have a chronic or severe problem. Even with more chronic individuals, groups serve as an excellent complement to individual therapy. A drawback of groups is that the attrition rate is often much higher than it is in individual therapy. Dropouts tend to be younger and more isolated. They are less likely to be employed, married, or sexually active and are more likely to have a diagnosis of a personality disorder (Merrill, Mines, & Starkey, 1987).

Prevention

The prognosis for recovery from an eating disorder is far greater if treatment begins before the disorder becomes chronic (Kiemle et al., 1987). Early identification is imperative so that individuals can be treated before developmental delays become disabling.

Professionals who are in contact with adolescents at risk for developing eating disorders should be alert to possible clues. Although any one indicator may arouse suspicion, the professional should be aware of a combination of indicators over an extended period of time (Neuman & Halvorson, 1983). The first indicators may be a change in behavior or personality. Possible indicators of anorexia nervosa are sudden noticeable weight loss, isolation from peers, increase in exercise and activity level, denial of fatigue, excessive studying without improvement in grades, claiming to feel fat when under or normal weight, denial of hunger and chronic dieting, preoccupation with food and calories, mood fluctuations, and low self-esteem.

Possible indicators of bulimia nervosa are evidence of binge eating, chronic dieting, use of vomiting and laxatives, frequent trips to the bathroom after meals, irritability, mood fluctuations, and low self-esteem. Adolescents who are at high risk are those in the performing arts, gymnasts, wrestlers, cheerleaders, and track team members. Adolescents who are suspected of having an eating disorder should be approached gently and should be assessed. Professionals should be prepared to provide referrals to community therapists who specialize in eating disorders work.

Professionals also can participate in primary prevention by educating students, parents, and the public about eating disorders. Teachers and other professionals need to advocate healthy goals and attitudes and must help adolescents challenge some unhealthy cultural attitudes. Adolescents should have access to groups that teach coping skills such as assertiveness and stress management and should receive affective education to help them deal effectively with their feelings and enhance their self-esteem. Lastly, professionals should help reintegrate eating disordered adolescents into the mainstream after they have been ill. Support groups can help these individuals to readjust to life without an eating disorder.

References

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders.* (3rd ed. rev.). Washington, DC: Author.

Anderson, A.E. (1985). *Practical comprehensive treatment of anorexia nervosa and bulimia.* Baltimore, MD: Johns Hopkins University Press.

Bohanske, J., & Lemburg, R. (1985). *An intensive group process treatment model for the treatment of bulimia.* Presentation at the Center for the Study of Anorexia and Bulimia, 4th Annual Conference, pp. 1–24.

Boskind-Lodahl, M., & White, W.C. (1978). The definition and treatment of bulimarexia in college women—A pilot study. *Journal of American College Health Association, 27,* 84–86.

Brotman, A.W., Rigotti, N., & Herzog, D.B. (1985). Medical complications of eating disorders: Outpatient evaluation and management. *Comprehensive Psychiatry, 26*(3), 258–269.

Bruch, H. (1982). Anorexia nervosa: Therapy and theory. *American Journal of Psychiatry, 139,* 1531–1538.

Casper, R. (1983). On the emerging of bulimia nervosa as a syndrome: A historical view. *International Journal of Eating Disorders, 2*(3), 3–15.

Crowther, J.H., Post, G., & Zaynor, L. (1985). Prevalence of bulimia and binge eating in adolescent girls. *International Journal of Eating Disorders, 4*(1), 29–42.

Fairburn, C. (1985). Cognitive behavioral treatment for bulimia. In D.M. Garner & P.E. Garfinkel (Eds.), *Handbook of psychotherapy for anorexia nervosa and bulimia.* New York: Guilford Press.

Fallon, J., & Rozin, R. (1985). Body image of size estimates. *Journal of Consulting and Clinical Psychology, 53*(3), 276–286.

Garner, D.M. (1985). Iatrogenesis in anorexia and bulimia nervosa. *International Journal of Eating Disorders, 4*(4), 701–726.

Garner, D.M. (1986). Cognitive therapy for bulimia nervosa. In S.C. Feinstein (Ed.), *Adolescent psychiatry.* Chicago: University of Chicago Press.

Garner, D.M., & Bemis, K.M. (1982). A cognitive-behavioral approach to anorexia nervosa. *Cognitive Therapy and Research, 6,* 123–150.

Garner, D.M., Garfinkel, P.O., Schwartz, D., & Thompson, M. (1980). Cultural expectations of thinness in women. *Psychological Reports, 47,* 483–491.

Gross, J., & Rosen, J.C. (1988). Bulimia in adolescents: Prevalence and psychosocial correlates. *International Journal of Eating Disorders, 7*(1), 51–61.

Hall, A. (1985). Group psychotherapy for anorexia nervosa. In D.M. Garner & P.E. Garfinkel (Eds.), *Handbook of psychotherapy for anorexia nervosa and bulimia.* New York: Guilford Press.

Halmi, K., Falk, J., & Schwartz, E. (1981). Binge eating and vomiting: A survey of a college population. *Psychological Medicine, 11,* 697–706.

Hudson, J.I., Laffer, P.S., & Pope, H.G. (1982). Bulimia related to affective disorder by family history and response to dexamethasone suppression test. *American Journal of Psychiatry, 137,* 695–697.

Inbody, D.R., & Ellis, J.J. (1985). Group therapy with anorexic and bulimic patients: Implications for therapeutic interventions. *American Journal of Psychotherapy, 39*(3), 411–419.

Johnson, C., Connors, M., & Stuckey, M. (1983). Short term group treatment of bulimia. *International Journal of Eating Disorders, 2*(4), 199–207.

Johnson, C., & Maddi, K.L. (1986). The etiology of bulimia: Bio-psycho-social perspectives. *The Annals of Adolescent Psychiatry, 13,* 1–10.

Kaplan, S.L., Busner, J., & Pollack, S. (1988). Perceived weight, actual weight, and depressive symptoms in a general adolescent sample. *International Journal of Eating Disorders, 7*(1), 89–96.

Kiemle, G., Slade, P.D., & Dewey, M.E. (1987). Factors associated with abnormal eating attitudes and behaviors: Screening individuals at risk of developing an eating disorder. *International Journal of Eating Disorders, 6*(6), 713–724.

Killen, J.D., Taylor, C.B., Telch, M.J., Saylor, K.E., Maron, D.J., & Robinson, T.N. (1987). Evidence for an alcohol-stress link among normal weight adolescents reporting purging behavior. *International Journal of Eating Disorders, 6*(3), 349–356.

Klesges, R.C., Mizes, J.S., & Klesges, L.M. (1987). Self help dieting strategies in college males and females. *International Journal of Eating Disorders, 6*(3), 406–417.

Lacey, J.H. (1983). An outpatient treatment program for bulimia nervosa. *International Journal of Eating Disorders, 2*(4), 209–213.

Laessle, P.G., Zoettl, C., & Pirke, K.M. (1987). Meta-analysis of treatment studies for bulimia. *International Journal of Eating Disorders, 6*(5), 647–653.

Leon, G., Carroll, K., Chernyk, B., & Finn, S. (1985). Binge eating and associated habit patterns within college student and unidentified bulimia populations. *International Journal of Eating Disorders, 8*(1), 43–57.

Loro, A. (1984). Binge eating: A cognitive-behavioral treatment approach. In R.C. Hawkins, II, W.J. Fremouw, & P. Clement (Eds.), *The binge-purge syndrome: Diagnosis, treatment, and research.* New York: Springer.

Merrill, C.A., Mines, R.A., & Starkey, R. (1987). The premature drop-out in the group treatment of bulimia. *International Journal of Eating Disorders, 6*(2), 293–300.

Mitchell, P.B. (1988). The pharmacological management of bulimia nervosa: A critical review. *International Journal of Eating Disorders, 7*(1), 29–41.

Neuman, P.A., & Halvorson, P.A. (1983). *Anorexia nervosa and bulimia: A handbook for counselors and therapists.* New York: Van Nostrand Reinhold.

Orleans, T., & Barnett, L. (1984). Bulimarexia: Guidelines and behavioral assessment and treatment. In R.C. Hawkins, II, W.J. Fremouw, & P. Clement (Eds.), *The binge-purge syndrome: Diagnosis, treatment, and research.* New York: Springer.

Polivy, J., & Herman, C.P. (1987). Diagnosis and treatment of normal eating. *Journal of Consulting and Clinical Psychology, 55*(5), 635–644.

Pope, H., Hudson, J., & Jonas, J. (1984). Bulimia treated with imipramine: A placebo, controlled, double-blind study. *American Journal of Psychiatry, 140*, 554–558.

Powers, P., & Powers, H. (1984). Inpatient treatment of anorexia nervosa. *Psychosomatics, 25*(7), 512–527.

Pyle, R., Mitchell, J., Eckert, E., Hatsukami, D.K., & Goff, G. (1984). The interruption of bulimic behavior: A review of three treatment programs. *Psychiatric Clinics of North America, 7*(2), 275–286.

Rock, C.L., & Yager, J. (1987). Nutrition and eating disorders: A primer for clinicians. *International Journal of Eating Disorders, 6*(2), 267–280.

Russell, G. (1979). Bulimia nervosa: An ominous variant of anorexia nervosa. *Psychological Medicine, 9*, 429–448.

Russell, G. (1985). Bulimia revisited. *International Journal of Eating Disorders, 4*(4), 681–692.

Sargent, J., Liebman, R., & Silver, M. (1985). Family therapy for anorexia nervosa. In D.M. Garner & P.E. Garfinkel (Eds.), *Handbook of psychotherapy for anorexia nervosa and bulimia*. New York: Guilford Press.

Schwartz, R.C., Barrett, M.J., & Saba, G. (1985). Family therapy for bulimia. In D.M. Garner & P.E. Garfinkel (Eds.), *Handbook of psychotherapy for anorexia nervosa and bulimia*. New York: Guilford Press.

Silverstein, B., Perdue, L., Peterson, B., Vogel, L., & Fantini, D. (1986). Possible causes of the thin standard of bodily attractiveness for women. *International Journal of eating Disorders, 5*(5), 905–916.

Striegel-Moore, R.H., McAvay, G., & Rodin, J. (1986). Toward an understanding of risk factors for bulimia. *American Psychologist, 41*(3), 246–263.

Strober, M. (1984). Stressful life events associated with bulimia in anorexia nervosa. *International Journal of Eating Disorders, 3*(2), 3–15.

Strober, M., & Yager, J. (1985). A developmental perspective on the treatment of anorexia nervosa in adolescents. In D.M. Garner & P.E. Garfinkel (Eds.), *Handbook of psychotherapy for anorexia and bulimia*. New York: Guilford Press.

Stuber, M., & Strober, M. (1987). Group therapy in the treatment of adolescents with bulimia. *International Journal of Eating Disorders, 6*(1), 125–131.

Vandereycken, W. (1987). The constructive family approach to eating disorders: Critical remarks in the use of family therapy in anorexia and bulimia. *International Journal of Eating Disorders, 6*(4), 455–465.

Walsh, B.T. (1988). Anti-depressants and bulimia: Where are we? *International Journal of Eating Disorders, 7*(3), 421–423.

White, J. (1984). Bulimia: Utilizing individual and family therapy. *Journal of Psychosocial Nursing, 22*(4), 22–28.

Wolchik, S., Weiss, L., & Katzman, M. (1986). An empirically validated, short term psychoeducational group treatment program for bulimia. *International Journal of Eating Disorders, 5*(1), 21–34.

Wooley, S., & Wooley, O. (1979). Obesity and women I: A closer look at the facts. *Women's Studies International Quarterly, 2*, 69–79.

Yager, J. (1985). The outpatient treatment of bulimia. *Bulletin of the Menninger Clinic, 49*(3), 203–226.

Chapter 9

FEMALE, SINGLE, AND PREGNANT: ADOLESCENT UNWED MOTHERS

Rosemary Thompson and Ardis Sherwood

Introduction

The incidence of pregnancy and the number of out-of-wedlock births to school-age adolescent girls are increasing at an alarming rate. There are 10 million women in the United States between the ages of 15 and 19, and each year, over 1.1 million of these young women become pregnant (Alan Guttmacher Institute, 1984; Children's Defense Fund, 1988). Every day, more than 3,000 adolescent women become pregnant, 2,300 of these pregnancies are unintentional, and 1,300 of these pregnancies result in live births (Edelman, 1987). Nearly three quarters of these pregnancies occur among unmarried teenage women (O'Connell & Rogers, 1984), and it is estimated that more than 90% of these adolescent mothers keep their babies (Ascher, 1985). Perhaps most disturbing are the data that reveal that 125,000 girls under age 15 become pregnant each year (Children's Defense Fund). Each day, 26 children between the ages of 13 and 14 will have their first baby, and thirteen 16-year-old girls will have their second child (Edelman, 1987).

Studies have indicated that the majority of sexually active teenagers do not want to become pregnant, and according to The Alan Guttmacher Institute (1981), 80% of all teenage pregnancies were unanticipated. Despite the fact that many adolescents are knowledgeable about how to obtain and use contraceptives, most teenagers do not practice contraception or, when they do, the methods are erratic and irregular (Alan Guttmacher Institute, 1981). A study of 134 sexually active adolescents revealed that only 22% of the women and 33% of the men reported ever having used contraceptive measures (Kyman, Berger, & Perez, 1987), and research conducted by The Alan Guttmacher Institute (1981) and Zabin et al. (1981) indicated that teenagers begin to seek birth control advice after they have been sexually active for 9 to 12 months. It is, therefore, not surprising that half of all first premarital pregnancies occur during the first 6 months of sexual activity (Alan Guttmacher Institute, 1981).

The statistics on teenage pregnancy do not summarize adolescent sexuality, but they do confirm that many adolescents initiate sexual activity during a developmental stage that is characterized by risk-taking behavior and a propensity to act without a full sense of the potential consequences of their actions.

Numerous studies over the past decade have indicated that one of the most profound trends among American adolescents is a significant increase in both pregnancy (Dryfoos & Heisler, 1978) and the subsequent rearing of offspring by single, school-age mothers (Ogg, 1976). The percentage of teenage pregnancy and childbirth is significantly higher in the United States than in any other industrialized nation (Brozan, 1985). This trend is becoming a national concern, and is considered by many to be an epidemic (Baizerman, Sheehan, Ellison, & Schlesinger, 1971; Braen & Forbush, 1975; Furstenburg, 1969; Klerman, 1975; Piotrow, 1975). A study by Ogg (1976) indicated that the number of one-parent families has increased seven times as rapidly as the number of traditional two-parent families, and a growing proportion of these single-parent families are represented by never-married teenagers. According to Nye (1976), school-age children between 14 and 16 years of age are the most rapidly increasing age group of single parents, and Moore and Caldwell (1977) estimated that "of all children born out of wedlock, at least 60% end up on welfare" (p. 164).

There is a pervasive need for programs that focus on personal functioning and offer comprehensive services that address the needs of unwed adolescent mothers, but parents, school administrators, counselors, and social agencies are frequently ambiguous about which methods and approaches should be taken to assist young mothers and their children. The dilemma is multidimensional, and involves many physical, psychological, educational, and socioeconomic issues. There are also numerous intervening and escalating variables (such as poverty and the lack of job entry skills) that contribute to the psychological distress of these young mothers. Essentially, there is a vital demand for adequate collective services, as well as for programs that would enhance the well-being and promote self-sufficiency in single teenage mothers, yet the potential change agents in the community remain elusive about who will take the responsibility for providing social support and services for this growing at-risk population.

Various research efforts have been conducted to identify factors associated with adolescent pregnancy. These studies indicate that, for a significant number of adolescents, certain antecedent events, influences, and interpersonal characteristics seem to be present before the onset of a teenage pregnancy. A very high proportion of young, pregnant, single mothers come from economically and socially deprived backgrounds (Children's Defense Fund, 1988). Research by Kaplan, Smith, and Pokorny (1979) suggests that these young women are likely to identify their families, schools, and peers as sources of self-devaluing experiences, and Michaels and Brown (1983) found that the choice for motherhood in teenagers is inversely related to having other sources of satisfaction. The literature also documents that various accompanying attendant conditions, influences, and personal characteristics emerge during the time of pregnancy. Early motherhood is associated with a significant reduction in education (Ireson, 1984; Moore & Waite, 1977), and Barth, Schinkle, and Maxwell (1983) concluded that adolescent pregnancy and childbearing contribute to a lowered self-esteem and a predisposition toward depression. Many proponents of adolescent health and well-being report a number of ominous concerns because of the potential social, psychological, and economic hardships of the adolescent mother. In addition, correlational studies have identified certain factors, such as socioeconomic status, that are beyond the scope of influence of any single public or private agency.

The fact that many adolescents are becoming parents before they finish high school is an educational and economic problem that policymakers, community members, and educators cannot afford to ignore. Inherently, the legacy of adolescent parents will be their own children who will, in turn, perpetuate the cycle of poverty and become the next generation of at-risk youth.

This chapter will provide an overview of precipitating variables and the long-range consequences of adolescent pregnancy. Potential interventions and a multimodal model for assisting adolescents will be discussed, and recommendations for preventing pregnancy through a shared commitment from public and private agencies will be provided.

Relevant Studies

Demographic Variables

Early parenthood and illegitimacy are associated with (a) lower education and occupational attainment (Edelman, 1988; La Rue & Miller, 1988; Ireson, 1984; Ventura, 1984); (b) marital instability (Moore, 1983);

(c) closer spacing of subsequent children and larger completed family size (Wilson, 1986), and (d) poorer mental and physical health of the mother and the child (Mecklenburg & Thompson, 1983; Millman & Hendershot, 1980). In addition, an absent father figure and greater number of siblings in the teenager's family correlate positively to the risk of adolescent pregnancy (Furstenburg, 1976; Goldfarb, Mumford, Schum, Smith, Flowers, & Schum, 1977; Hogan & Kitagawa, 1983).

For female adolescents, the risk of pregnancy is related to race (Alan Guttmacher Institute, 1981; Ventura, 1984), low socioeconomic status (Burden & Klerman, 1984), and absence of the father, number of siblings, school difficulties, and family stress (Dryfoos, 1985). Among adolescent men, early fatherhood is associated with school difficulties, low parental economic status (Robbins, Kaplan, & Martin, 1985), and race (Barret & Robinson, 1982).

The roles of the demographic variables, including socioeconomic status, race, and ethnicity are multidimensional. This is clearly illustrated by a research perspective on the complexity of the early childbearing phenomenon (Mott, 1986). Initial studies indicated that the mother's age at the time of her first pregnancy was related to the number of subsequent pregnancies she would experience. It was believed that a higher probability of repeated pregnancies existed when she became pregnant at an early age. More recent research reveals that these data differentiate by age among population subgroups. There are no significant differences in repeat pregnancies between White adolescents who experience early childbirth and White women who postpone their first birth until their early 20s. Black adolescents, who give birth at an early age, are more likely to have a rapid follow-up birth, and the younger the mother is, the sooner this second child will be born. Hispanic women are more likely than either their Black or White counterparts to have a second baby quickly follow an early first birth, but there are not any significant differences between the younger and older Hispanic teenagers regarding the timing of this second birth (Mott). These subtle differences have implications for early and primary prevention programs.

Interpersonal Variables

The quality of the relationship between the parents and the teenager is a relevant antecedent factor that contributes to the early initiation of premarital sexual relationships. The degree of interpersonal closeness versus distance or alienation in the mother-daughter relationship, as well as estrangement from the family, are factors that have been found to be significant antecedents to adolescent pregnancy (Chilman, 1980; Olson & Worobey, 1984). A strong relationship with the mother can prevent the daughter from prematurely losing herself in relationships with others. Abernethy (1974) found that family experiences during adolescence are critical in determining personality traits and predispositions for early pregnancy. If the parents' marriage is characterized by distance and hostility, promiscuity and irresponsible use of contraception are common outcomes. Poor identification with a mother "who was neither warm nor respected" is a common expression of adolescent mothers in this study (Abernethy).

Fox (1980) gathered data on communication about sexual behavior and found that a higher frequency of communication with the mother about sexual questions is associated with the daughter exhibiting a more responsible pattern of sexual behavior. Frequent discussions provide an "anticipatory rehearsal," and permit the daughter to accept her sexuality. This open communication also desensitizes the topics of sex and birth control, and facilitates the probability that a discussion about responsible sexual behaviors will also occur with future sexual partners.

Psychological Variables

Adolescent mothers may be especially vulnerable to emotional problems. Among the traits purportedly manifested in the emotional repertoire of adolescent mothers are (a) weak ego strength (Miller, 1973); (b) self-devaluation (Kaplan et al., 1979); (c) low self-worth (Faigel, 1967); (d) low self-esteem (Thompson, 1986); (e) inability to plan for the future (Rains, 1971); (f) proclivity toward denial (Rader, Bekker, Brown, & Richardt, 1978); (g) risk-taking behavior (Miller); and (h) external locus of control (Connolly, 1975; Thompson).

Although studies have indicated that the life changes that accompany pregnancy and childbearing contribute to the psychological stress of teenage mothers, the two variables that are systematically shown to be associated with their emotional distress are poverty and isolation (Barth et al., 1983). Socioeconomic characteristics have a significant impact on the emotional well-being of adolescent mothers. Evidence strongly suggests that the lack of social supports and a reduced economic status mediate the stress of adolescent motherhood (Barrera, 1981; Furstenburg & Crawford, 1978; Grow, 1979), and McGee (1982) contended that the social and economic limitations that are imposed on single, adolescent mothers are sufficient to generate many of the adverse characteristics associated with teenage mothers. Furthermore, these emotional difficulties continue to plague low-income mothers even after their children have entered high school (Brown, Adams, & Kellam, 1981). The debilitating influence of welfare status is seen as a major contributor to young mothers' distress (Burden & Klerman, 1984; Ensminger, 1979).

Barth et al. (1983) maintained that social supports in the form of social, economic, and educational assistance is the primary need for teenage mothers. Their study revealed that social and economic factors contribute more to the adolescent mother's emotional well-being than does pregnancy or parenthood. Although the aspect of motherhood may somewhat distress the adolescent, the lack of emotional and social support is the major contributor to her emotional stress, and it is crucial that assistance programs for adequate social and material assistance be initiated (Barth et al.).

Correlates of Early Childbearing to Education, Career, and Economic Well-Being

A few studies have identified a number of critical concerns for teenage mothers and their offspring (Center for Population Options, 1985; Children's Defense Fund, 1988; Edelman, 1987; Furstenburg, 1976; Hofferth & Moore, 1979; Kellam, 1979; McCarthy & Menken, 1979; Morrison, 1978; National Research Council, 1987; Russ-Eft, Sprenger, & Beever, 1979; Sandler, 1979; Ventura, 1984; Wilson, 1986). The concomitant events of adolescent pregnancy and the long-range educational and economic consequences have serious implications for this growing population of at-risk youth and their children.

There are significant relationships among an early first birth, education, meager marketable skills, and a limited, financially unrewarding labor force experience. School failure is a recurring predictor in both the antecedent and accompanying factors related to adolescent pregnancy. The "status failure" explanation, proposed by Robbins et al. (1985), suggests that marginal students become pregnant because parenthood seems a viable alternative to the self-devaluing experiences in the educational system. School stress, therefore, is considered to be a strong predictor of adolescent pregnancy. Conversely, the degree of educational attainment is highly correlated with the age of the mother when she bears her first child (Rindfuss, Bumpass, & St. John, 1989). Moore and Hofferth (1978) found that, in virtually every study, the age of the mother at the time of the birth of her first child presents the strongest influence on her educational attainment. The primary effect of a birth on educational achievement occurs among women who bear their first child during their high school years.

Adolescent mothers, because of their loss of education, generally not only work less, but have lower hourly wages, earn less money annually, and obtain jobs with lower occupational prestige and less opportunity for advancement. Eight out of 10 women who have their first child at age 17 or earlier never complete high school (Moore & Hofferth, 1978). Even when the first birth occurs at age 18 or 19, the rate for dropping out of school is 1.4 times greater than that of the general teenage population (Alan Guttmacher Institute, 1976). Other investigators (Scales & Gordon, 1979; Trussell, 1975) found that the younger the girl is at the time she becomes pregnant, the less likely she is to return to school after delivering her baby. Teenage mothers have an 85% dropout rate, whereas childless girls have a 7% to 9% dropout rate (Alan Guttmacher Institute, 1976). Young women who have a first birth before age 15 have an average educational attainment of only 8.9 years. This is 4 years less than the national average. Women who bear their first child at ages 16 or 17 receive approximately 10.5 years of schooling, 18-year-old mothers attain 11.3 years, and 19- to 20-year-old mothers average 11.9 years. Even women who become mothers at ages 21 to 23 are below the national average. They typically obtain 12.7 years of education, whereas women who have their first child at age 24 or older have an average educational level of 13.5 years. These additional years of education can create significant elevations in the possibilities for increased wages and job opportunities (Dillard & Pol, 1982).

Pregnancy not only disrupts schooling but also minimizes the acquisition of vocational skills. The new responsibilities that accompany child care can make it difficult to obtain employment. Welfare often becomes the only viable alternative. In a New York City study (Pressor, 1980), it was found that 72% of mothers who gave birth between the ages of 15 and 17 were being supported by Aid to Families of Dependent Children (AFDC). This study also reported that one third of the mothers who have their first child between the ages of 13 and 15 live below the federal poverty level. This incidence is 2.6 times greater than that of women who postpone childbearing until the age of 20 or later (Pressor).

Parenthetically, as the training and educational demands of our society become more sophisticated and the opportunities to meet these demands continually become exhausted, without prerequisite skills, the adolescent mother becomes disenfranchised and invariably handicapped. As Table 1 shows, the probability of opportunity, education, employment, and economic stability is diminished, and single parenthood becomes synonymous with poverty. Furthermore, the public cost of adolescent pregnancy is expensive. For each family that originated from a teenage pregnancy, the cost is approximately $14,000 per year for a 20-year interval. In 1986 alone, $18 billion in federal assistance (including AFDC, food stamps, and Medicaid) went to families that emanated from a teenage birth (Children's Defense Fund, 1988).

Summary

In summary, the variables associated with teenage pregnancy are complex and numerous. Lists of the antecedent and attendant demo-

TABLE 1

Profile of Adolescent Mothers in the Years After Their Children are Born

	Age of Mother				
	Younger than 15	*15 to 17*	*18 to 19*	*15 to 19*	*20 to 24*
Health					
Receiving late or no prenatal care	65.3%	52.7%	44.8%	30.0%	
Babies born at low birthweight	12.9%			9.3%	6.9%
Marital Status					
Married at birth of child	8.0%	33.2%	49.3%		73.7%
Of mothers who were unmarried at birth of child, percent who married within:					
One year		19.1%	24.0%		19.4%
Three years		38.6%	44.1%		41.5%
Of women who marry at various ages, percent who separate within five years:					
		23.7%	14.8%		9.9%
Repeat Pregnancies and Births					
Of women who have their first child at various ages, percent who have a repeat birth within:					
Two years	26.0%	20.0%	22.0%		
Three years	42.0%	41.0%	46.0%		
Of teens having a premarital first pregnancy, percent who have a second premarital pregnancy within:					
12 months				17.1%	
18 months				25.5%	
24 months				37.8%	

School Completion					
Of high school sophomores, percent who dropped out before graduation:					
Unmarried, with child		51.4%			
Married, with child		75.4%			
Unmarried, no child		7.9%			
Married, no child		59.6%			
Percent of teens who had their first child at various ages, who had completed high school by ages 20 to 26:					
Total		50.2%	70.2%	61.1%	90.0%
Diploma		32.0%	60.7%	47.6%	86.0%
G.E.D.		18.2%	9.5%	13.0%	4.0%
Poverty					
Of women in their mid-20s who had their first child at various ages, percent whose incomes were below 150% of poverty:					
	78.0%	50.0%	51.0%		29.1%
Welfare Recipiency					
Of women who had their first child at various ages, percent who started receiving welfare within four years:					
Total (married and unmarried)		52.0%	42.0%	46.0%	
Unmarried at birth of child		73.0%	73.0%	73.0%	
Of women who had their first child at various ages and who started receiving welfare, percent who left welfare within four years:					
Total (married and unmarried)		70.0%	82.0%	76.0%	
Unmarried at birth of child		66.0%	76.0%	71.0%	

From *Model Programs: Preventing Adolescent Pregnancy and Building Youth Self-Sufficiency* (p. 9), 1988, Washington, DC: Children's Defense Fund. © 1988 by The Children's Defense Fund. Reprinted by permission.

graphic, interpersonal, and psychological variables, influences, and personal characteristics are provided below (Alan Guttmacher Institute, 1981, 1984; Children's Defense Fund, 1988; Crim, 1987; Cvetkovich & Grote, 1975; Finkel & Finkel, 1975; Goldsmith, Gabrielson, & Gabrielson, 1972; Hornick, Doran, & Crawford, 1979; Jorgenson, King, & Torrey, 1980; Koenig & Zelnik, 1982; Planned Parenthood Poll, 1986; Pressor, 1980; Shah, Zelnik, & Kantner, 1975; Zelnik & Kantner, 1979).

Demographic Variables

1. Younger than 18 years of age, with a growing population of adolescents younger than 15 years of age;
2. Low socioeconomic status;
3. Minority group membership;
4. Academically behind in school; low grade point average;
5. Larger than average family;
6. Familial correlates; and
7. Absent father figure.

Interpersonal Variables

1. Not committed to a steady relationship;
2. Sporadic, unplanned sexual activity;
3. Nonusage of contraceptives;
4. No access to free, confidential family planning services;
5. Distant or hostile family relationships;
6. Often in high-stress situations;
7. Sexually permissive friends;
8. Tolerant family attitudes toward early sexual activity and pregnancy;
9. Fewer demands, greater rejection, and more casualness in mother-daughter relationship; and
10. Less love, less attention, and less self-disclosure in relationship with mother.

Psychological Variables

1. Desiring pregnancy to fill a love void, or to secure a commitment from a partner;
2. External locus of control;

3. Low self-esteem;
4. Attitudes of fatalism, powerlessness, and alienation;
5. High levels of anxiety;
6. Low ego strength;
7. Risk-taking behavior; pleasure-oriented attitudes; and
8. Depression.

Composite Profile of the Average Unwed Adolescent Mother

1. Her mother or sister was a teenage mother.
2. She was reared in a single-parent home.
3. Her family was often a recipient of AFDC.
4. She does poorly in school.
5. She is influenced by peer pressure.
6. She has a rigid sense of the gender roles.
7. She is experiencing family stress.
8. She feels she has no control over her life.
9. She has low self-esteem.

Approaches to Counseling

From a counseling perspective, there are a number of salient issues to consider. The problem of adolescent pregnancy can be prevented at various developmental stages of behavior and experience. The adolescent who is not engaging in sexual activity can be encouraged to continue abstinence until he or she is mature enough to assume responsibility for his or her sexual conduct. The adolescent who is already sexually active can be provided pertinent contraceptive information and counseling. The adolescent who is pregnant needs appropriate medical care and a versatile method of intervention that can effectively address all the problematic aspects of teenage pregnancy and motherhood.

The trend in current counseling processes and psychotherapy is toward a multidimensional, multidisciplinary, and multifaceted approach that does not rigidly attempt to fit clients into a preconceived treatment plan (Lazarus, 1984). One such approach, Multimodal Therapy (Lazarus, 1981), is a systematic and eclectic orientation that allows the counselor to take into account the uniqueness of each individual and to tailor a program that addresses the special issues and problems of that person. The emphasis in this therapeutic approach consistently pertains to what is the best outcome for the individual, couple, or group.

The following case study and intervention strategies are provided to illustrate the multimodal approach as one counseling alternative for the adolescent population.

Individual Counseling Approach

Jane was a 17-year-old high school senior. She was intelligent (IQ 119), and had previously demonstrated conscientious behavior and above-average academic achievement in school. She had few close friends, was not involved in many school-related extracurricular activities, and was considered to be shy and introverted by her teachers.

Jane was referred to the counseling office because she was exhibiting a behavioral transformation that included frequent absenteeism and declining grades. During the initial interview Jane appeared despondent, withdrawn, and was reluctant to discuss her current attendance and academic progress. She was encouragingly assured that the counselor would be available at any time for future conferences.

Jane returned to the counseling office the next afternoon. She had experienced some negative encounters with the teaching staff, and she was agitated and crying. She expressed frustration, anger, and fear regarding her academic progress, and during the counseling session, she revealed the underlying problem that was masked by her poor attendance and declining grades. Jane was 4 months pregnant.

Jane had moved out of her family home to live with her 19-year-old married boyfriend, John. This was her first intimate relationship. John was currently separated from his wife and had two children. The youngest child was 2 weeks old. John was a high school dropout and had been immature and irresponsible with his interpersonal relationships in the past. He suggested that Jane either have an abortion or relinquish the child for adoption. He viewed the baby as a threat and a potential financial burden, and told Jane that their relationship would not continue if she decided to keep the baby.

Jane had been struggling alone with her dilemma regarding a possible abortion, and when she was informed that she had passed the 12-week time limit to terminate the pregnancy, she expressed guilt as well as intense relief.

Jane's mother apparently believed that when her children became teenagers, she was no longer responsible for their care. According to Jane, her mother had condoned Jane's living arrangement with John, but she was unaware that Jane was pregnant. It seemed that Jane's primary support system (parents) was absent, and this fact created an additional predicament for the counselor and the counselee.

Numerous important considerations and issues emerged from this case. The apparent concerns were: (a) medical treatment of a minor, and (b) Jane's parents' neglect of and lack of responsibility toward their daughter. The counseling issues that arose were: (a) whether Jane would keep the baby or plan to have her child adopted; (b) the prospects of a marriage to John; (c) Jane's educational and career goals; (d) her own health and the future well-being of her child; and (e) her need to communicate with her mother about her pregnancy. Finally, at the emotional level, it was important to understand that Jane seemed to be receiving "double-bind" messages from John. If she put the baby up for adoption, she could stay with John and, presumably, their relationship would remain intact, but she would lose the child. If she kept the baby, she would lose John (and her first intimate relationship). Hence, the issues of separation and loss were obvious concerns for Jane and the counselor.

Jane eventually decided to set three goals. First and foremost, she would inform her mother about her pregnancy. Second, she would develop and implement a plan of action for herself regarding her physical well-being, and third, she would clarify her relationship with John.

Multimodal Therapy. A recommended counseling model to use with an individual, or with groups of adolescent mothers, is a multimodal approach, an application of Multimodal Therapy (Lazarus, 1981). This method of therapy is based on the assumption that counselees (or clients) are usually troubled by a multitude of specific problems, and an eclectic counseling program should be formulated to deal with each particular problem. Multimodal Therapy uses a unique assessment procedure that extensively examines both the client's individual sensory, imagery, cognitive, and interpersonal factors, and the interactive effects of these components. Lazarus (1984) provided a framework of seven modalities that are used to conduct this assessment, and this scheme is represented by the acronym, BASIC ID (B = Behavior; A = Affect; S = Sensation; I = Imagery; C = Cognition; I = Interpersonal Relationships; D = Drugs/Biology). Keat (1979) later modified the BASIC ID to address the needs and concerns of various populations, including children.

"The BASIC ID is presumed to comprise human temperament and personality" (Lazarus, 1984, p. 492), and it is assumed that all the emotions attributable to an individual can be accounted for by examining the components and interactions within that person's BASIC ID. It is also considered essential for the assessment to recognize and include the factors that are not addressed by the BASIC ID, such as sociocultural, political, and other macroenvironmental events (Lazarus, 1984). The great depth and detail entailed in the multimodal's examination of the sensory, cognitive, and interpersonal constituents and their interactive effects enable the counselor to transcend the confines of most cognitive-behavioral approaches.

This conceptual model empowers the counselor to evaluate the counselee systematically and comprehensively. By determining the areas of strengths and weaknesses, the counselor and counselee can develop a treatment plan that has a multidimensional influence on behavior.

Basic ID

B **Behavior** (observable habits, behaviors, and activities);
A **Affect** (feelings and emotional reactions);
S **Sensation** (physical concerns, sensory responses);
I **Imagery** (images and fantasies);
C **Cognition** (rational and irrational beliefs, goals, plans, philosophies);
I **Interpersonal Relations** (relationships with others); and
D **Drugs/Diet** (broadly defined as biological functioning, diet, health, and wellness).

The value of Multimodal Therapy is that it attends to specific problems or difficulties within a give modality as well as the interactions between this modality and each of the six other dimensions. When dealing with the multidimensional aspects of behavior, affect, sensation, imagery, cognition, and interpersonal relations (as well as focusing on the details about nutrition, exercise, and health concerns in the D modality), the emphasis is fundamentally educational. This blueprint of strategies enables the counselor to modify faulty coping techniques, offer guidance, provide a nurturing relationship, give congruent information, correct misconceptions, and deliver the support and encouragement necessary to assist the counselee in reaching her goals.

Counselees who present a wide range of concerns in a number of developmental areas (poor social skills, depression, anxiety, low self-esteem) can be particularly responsive to the multimodal model. When the needs of the counselee's entire behavioral repertoire are systematically addressed, the interventions can relieve the feelings of panic, frustration, and hopelessness that are often manifested in counselees with multiple problems. This method can be especially effective with adolescent mothers, who seem to exhibit a number of underlying social, emotional, and behavioral problems. This structure also allows the counselor to maximize the use of referral sources and adjunct modes of treatment. The multimodal orientation minimizes the use of time while it increases the personal and emotional benefits to the adolescent counselee (Lazarus, 1984).

Case Study Application

Jane manifested a broad range of concerns, so a multimodal assessment using the BASIC ID was employed during her counseling process. Table 2 details her individual assessment and treatment plan.

One of the basic assumptions of the multimodal approach is that the amount of effort expended by the counselor and the counselee will determine the stability and durability of the results of the counseling process (Lazarus, 1984). As the amount of adaptive and coping skills learned in therapy increases, the probability of a relapse to former dysfunctional behavior decreases. These enduring changes seem to depend on the combination of techniques, strategies, and modalities advocated by this therapeutic procedure.

During the counseling sessions Jane learned new and appropriate cognitive and behavioral skills, and the therapeutic process enabled her to make modifications in her maladaptive beliefs and self-defeating behaviors. The counseling process adhered to the basic premise of Multimodal Therapy that clients are usually troubled by a multitude of specific problems that should be dealt with by a similar assemblage of appropriate interventions (Lazarus, 1984). The counseling process focused on (a) positive reinforcement, (b) owning and accepting feelings, (c) changes in self-image, (d) cognitive restructuring, (e) nonjudgmental acceptance, and (f) recognizing and understanding paradoxical maneuvers or double-bind communications. Education, information, and training facilitated Jane's changes in assertive behavior, responses to stress, and the development of new problem-solving and interpersonal skills. For example, Jane's counselor successfully employed the principles of stress inoculation therapy (Meichenbaum & Cameron, 1973), a type of self-instructional training focused on altering dysfunctional self-statements in order to restructure a person's characteristic approach to stressful situations. This technique, which has been used to help people cope with anxiety (Meichenbaum & Novaco, 1978) and anger (Novaco, 1979), was particularly applicable in Jane's case. She was experiencing anxiety with her academic performance and her affiliation with her teachers. She was also angry and frustrated with her relationship with her partner. A critical concern for Jane was that she learn to obtain some control over her inner conflicts, and eventually gain self-sufficiency in her coping skills.

TABLE 2

Case Study: Jane

Individual Multimodal Counseling Profile for Adolescent Mothers

Modality	*Problem Assessment*	*Related Intervention*
Behavior	Avoiding telling mother of pregnancy	Behavior-rehearsal via taped playback
	Avoiding prenatal care	Participate in prepared childbirth program
	Negative self-statements	Positive self-talk assignments; goal rehearsal
Affect	Depression	Increase range of positive reinforcement
	Internalized anger	Assertiveness training; behavioral rehearsal
	Feelings of guilt and anxiety	Self-hypnosis with positive imagery
	Feelings of loneliness and emptiness	Relationship building; communication skills
Sensation	Ambivalent feelings about prenatal care	Diet, exercise, improved eating habits

	Concern over well-being of baby	Education and training in anatomy and physiology
	Tension and fatigue	Relaxation training; stress inoculation
	Butterflies in stomach	Abdominal breathing exercises
Imagery	Telling boyfriend she will keep the baby	Goal rehearsal; coping imagery
	Image of self as incapable as student and mother	Social skills; assertiveness training; images of mastery; concentration on positive skills; diminish feelings of hopelessness and depression
	Image of self as unemployed and on welfare	Assertiveness training
Cognition	Lack of prenatal Information	Bibliography
	Lack of education and occupational data	Career counseling; individual assessment
	Irrational self-talk about low self-worth	Dispute irrational ideas
	Numerous regrets	Dismantle categorical imperatives (remove shoulds, musts, and oughts)

TABLE 2 *Continued*

Modality	*Problem Assessment*	*Related Intervention*
Interpersonal Relations	Fear of rejection by boyfriend and significant others	Behavioral rehearsal, assertiveness and communication training; time projection techniques
	Inconsistent relationship with parents	Family conference roleplaying, attend prepared childbirth class with mother
Drugs/Diet	Poor dietary habits	Encourage good nutrition

The strategies of Multimodal Therapy were therapeutic for Jane. She was provided an organized framework in which she could systematically address and resolve the specific deficits and excesses in her behavioral patterns.

The multimodal approach to counseling can also be extremely effective when it is applied to counseling groups of adolescent unwed mothers. Support groups are frequently advocated as the preferred mode of teaching and treating this adolescent population because the group process can provide a richer and more realistic training milieu for the resolution of interpersonal conflicts and deficiencies than can individual counseling.

Approach to Group Counseling

Group counseling is particularly suitable for adolescents because it provides a place in which they can discover that their problem situations are not unique. The group experience can provide opportunities for communication, observational learning, modeling, role playing, and behavior rehearsal, and can supply a safe environment where adolescents can express and encounter conflicting feelings. Adolescent group therapy is generally directed toward the elimination of the dysfunctional behaviors that circumvent self-sufficiency, and provides an active atmosphere in which adolescents can learn alternative appropriate methods of dealing with situations. Finally, as the group offers unconditional acceptance and supports the members when they attempt new behaviors, group participants will gain self-esteem, and they will eventually assume more control over their own behavior.

The multimodal approach to group therapy is focused on eliminating specific excesses and deficits in each group member's multimodal profile, as well as increasing the self-sufficiency of the entire group. The initial focus of the group is devoted to the construction of Modality Profiles for each group member (See Table 3). An attitude and atmosphere emphasizing the cooperative pooling of resources and the deliberate creation of helpful togetherness is stressed, and the fundamental goal of the group is to learn an adaptive set of coping skills that can be generalized to other situations.

Multimodal applications can also provide a valuable dimension to teen-parent support groups. A teen-parent group, which is designed to concentrate on self-sufficiency skills and to cooperate extensively with community agencies, can address the unique needs and concerns of young parents. One such group, Mothers and Others Means Success (M.O.M.S. (Thompson, 1986), focuses on ameliorating particular problems in an informal, safe, relaxing, accepting, and respectful atmos-

TABLE 3

Multimodal Group Counseling Profile for Adolescent Mothers

Modality	*Problem Assessment*	*Related Intervention*
Behavior	Poor academic performance and attendance problems	Self-contracting; recording and self-monitoring
	Negative self-statements	Practice positive self-talk
	High risk-taking behavior (drugs, child neglect)	Provide accurate information about potential risks to self and to child
	Diciplining children by yelling or hitting	Teach operant training principles in child management
Affect	Feelings of low self-worth	Increase range of positive reinforcement; focus on self-value and self-talk
	Anger toward significant others	Exercises in anger expression
	Conflict with others	Behavioral rehearsal; role reversal
	Depression	Grief counseling (e.g., loss of father of child, significant others and their approval, loss of status with peer group); discuss difference between thoughts and feelings; identify positive and negative categories

Sensation	Anxiety and depression over present circumstances and future goals	Anxiety-management training; goal rehearsal or coping imagery
Imagery	Unproductive fantasies	Guided imagery; reduce the discrepancy between one's real and ideal self-image; positive imagery; imaging rehearsal; idealized self-image; time projection technique
	Image of self as incapable	Role rehearsal
Cognition	Poor study habits	Study skills training; assertiveness training; share feelings about school, favorite subjects; discuss performance levels; seek specific subject or source of underachievement; examine behavioral consequences of underachievement; develop contractual agreements with core teachers
	Lack of educational or occupational information	Career counseling; assessment and information
	Sexual misinformation	Factual information; bibliography
	Expectations of failure	Positive self-talk

TABLE 3 *Continued*

Modality	*Problem Assessment*	*Related Intervention*
Interpersonal Relations	Poor relationships with peers	Social skills and assertiveness training; share feelings about family and friends; discuss relationships with peers
	Conflicting or dissatisfying interpersonal relationships	Assertiveness training; communication skills training; conflict resolution strategies; role play and practice with communication skills
Drugs/Diet	Poor dietary habit	Involvement in weight reduction program; nutrition and dietary information for self and for offspring

phere. Table 4 outlines the group objectives and intervention strategies of this program.

Approaches to More Extensive Programs

Individual and group counseling approaches can be effective in addressing the emotional deficiencies of small populations of pregnant and parenting teens, but there still exists an urgent need for expanded school programs directed toward the prevention of teenage pregnancy, and for renewed efforts to formulate and initiate plans that will increase the socioeconomic resources of adolescent mothers.

Recent studies by the Children's Defense Fund (1988), Edelman (1988) and La Rue and Miller (1988) identified a number of crucial issues in increasing the motivation and capacity of teens to prevent premature pregnancy and in promoting their development of competent parenting abilities and appropriate interpersonal skills. The following inventory of needs is provided as a suggested direction for the advancement of relevant programs.

1. *Education and strong basic skills*. Youths who are behind a grade or have poor school attendance are at high risk for early parenthood. Low-income and minority teens have greater rates of school failure.
2. *Jobs, building work-related skills, and work exposure*. Teens who perform poorly in school and become teen parents are often students with poor work-related skills. Because of the lack of exposure to workplace norms, many adolescents manifest behavioral patterns that are maladaptive to the workplace.
3. *A range of nonacademic opportunities for success*. Children and teens need to feel good about themselves. They need a clear vision of a successful and self-sufficient future. Self-sufficiency is related to self-esteem and self-perception. For youths who are not doing well in school, nonacademic avenues for success are crucial.
4. *Family life education and life planning*. All teens need sexuality and parenting training education to facilitate the integration of factual information into their concepts about themselves and their future. Parents, schools, and religious institutions need to communicate more effectively with the young about sexuality.
5. *Comprehensive adolescent health services*. Convenient health services that provide comprehensive care are needed for the teenage population.

TABLE 4

Group Objectives for Nine-Week Structured Sessions of M.O.M.S

The general goals for M.O.M.S. (Mothers & Others Means Success, (Thompson, 1986) are to reduce the incidence of future pregnancy and to increase the educational and employment opportunities of this high-risk population.

Sessions focus on adolescent sexuality, self-esteem, problem-solving skills, and other concerns of group members. The developmental and problem-solving orientation of this group is intended to foster an informal support group for the participants.

The major goal of this group, as a family educational model, is to help individuals cope with themes and conditions they currently perceive as insurmountable (such as child care or parental conflicts). Efforts will be made to begin interventions at the present functioning level of the group, and to employ viable methods to address their concerns.

Group Objectives

1. Address specific areas of concern individual group members hold
   - A. Facilitate discussion of parenting skills.
   - B. Identify the expectations and roles of parenthood.
   - C. Provide a local resource person from a community day-care unit for presentations to the group on entertaining small children and making inexpensive, educational toys.
   - D. Utilize the local library, public health department, mental health center, local child-care association, and the local department of social services to facilitate discussions on topics of special concern.
   - E. Teach the stages of child development from birth to 5 years of age.
2. Develop individual multimodal profiles
   - A. Identify individual strengths and weaknesses.
   - B. Develop a systematic treatment plan.
   - C. Share individual goals with the group.
3. Employ the services of resource agencies within the city to strengthen recipients' self-sufficiency skills as parents and as prospective parents
   - A. A resource person from a local federal project will present vital information to group members about child development and discipline.
   - B. A modified parenting program that focuses on such issues as responsibility, consistency, and encouragement will be presented as a series of structured experiences by a resource person from the local court division unit.
   - C. A workshop on necessary job entry skills, interviewing, and job application procedures will be provided.
   - D. The services of the local social service or community services board will be utilized.

TABLE 4 *Continued*

4. Improve self-esteem
    - A. During the group process, the leader will focus on the members' strengths rather than on their weaknesses.
    - B. Positive reinforcement from other members will be encouraged.
    - C. Cooperative interaction among group members and structured strategies will facilitate the development of self-esteem.

5. Improve problem-solving skills
    - A. Leader will guide the group through problem-solving processes by stimulating, motivating, and involving the members in discussions on topics selected by the group.
    - B. Members will repeatedly rehearse and role play authentic situations. Focus will center on: (a) gaining control of life situations; (b) enhancing the individual's sense that she has the power to influence her environment; (c) understanding that choices and decisions have consequences that can affect one's life.
    - C. Members will identify the stress response and learn techniques to cope with stress and to manage stressful situations and problems.

6. Offer family planning and sexual information to adolescents
    - A. A local family planning workshop will be presented.
    - B. A basic understanding of the reproductive process, alternative methods of birth control, and the identification of sexually transmitted diseases will be provided.

7. Develop a continuing informal network among the group participants

---

6. *A national and community climate that makes teenage pregnancy a leading priority*. It is necessary to have caring adults who will provide positive role models, values, and support for teens.
7. *Development of broad-based educational programs*. It is essential that programs that place sex education within the larger context of life-skills development be implemented.
8. *Federal intervention*. The federal government should withhold funds from schools that exclude pregnant adolescents, and provide incentives that will facilitate the involvement of parents and grandparents in caring for the pregnant teenagers in their families.
9. *Increased community health services*. It is necessary to establish programs that address issues such as poor family communications, single parenting, conflicts between parents and ado-

lescent children, and early identification of abuse and abusive patterns.

10. *Policies and programs that focus on the family as well as on the individual*. The principal focus should be prevention, with efforts targeted in five areas: (a) reducing the incidence of teenage pregnancy; (b) reducing the incidence of repeat teenage pregnancy; (c) reducing the number of teenage school dropouts as a result of pregnancy and parenting; (d) reducing the number of babies born to low-income mothers who have not had comprehensive health care; and (e) providing good basic skills to young people to increase their chances to graduate from high school, obtain a college education or get a job, and generate healthy families (Children's Defense Fund, 1988).

Conclusions

The information provided in this chapter establishes the necessity for parents and private and public agencies to generate a concerted and extended effort toward increasing the self-sufficiency and personal success of adolescent unwed mothers. The interventions provided for this population should not only apply to the needs and concerns of the mother, but must simultaneously address the welfare of the unborn child. Adolescent mother programs must also teach adequate parenting skills and provide the structures that enable the counselor to use an approach that will facilitate the future well-being of the mother and her child.

The research on self-concept and maladjustive behaviors has indicated that a large number of adolescent unwed mothers could be highly susceptible to distress and emotional disturbance. Essentially, they deviate from the norms of their peer group because of the roles and responsibilities they must assume as a single parent. It is imperative that individual or group counseling be provided to assist this growing population of extremely vulnerable young people.

Because this adolescent population typically manifests an extensive range of disturbances, the most comprehensive and efficient method of intervention for teenage mothers could be a multimodal behavioral group counseling approach. The following recommendations are provided for possible consideration in the counseling process.

1. Interventions should focus on conflict, instability, low self-esteem, and self-sufficiency.
2. Education and training should be provided to increase personal management and problem-solving capabilities, and to generate sound job-entry skills.

3. The counseling process should facilitate the enhancement of social competence, and the ability to develop healthy interpersonal relationships.
4. Above all, the counseling process should be directed toward the adolescent mother's realization that she is ultimately responsible for herself, and that the achievement of her aspirations will predominantly depend on the amount of effort she extends toward her chosen goals. (For additional information on available resources, see the appendix.)

References

Abernethy, V. (1974). Illegitimate conception among teenagers. *American Journal of Public Health, 64*, 622–665.

Alan Guttmacher Institute. (1976). *11 million teenagers.* New York: Author.

Alan Guttmacher Institute. (1981). *Teenage pregnancy: The problem that hasn't gone away.* New York: Author.

Alan Guttmacher Institute. (1984). *U.S. and cross-national trends in teenage sexual and fertility behavior.* New York: Author.

Ascher, C. (1985). *Pregnant and parenting teens: Statistics, characteristics, and school-based support systems.* New York: ERIC Clearinghouse on Urban Education, Institute on Urban and Minority Education, Teachers College, Columbia University.

Baizermann, H., Sheehan, C., Ellison, D., & Schlesinger, E. (1971). Pregnant adolescents: A review of literature with abstracts, 1960–1970. *Sharing Supplement, Consortium on Early Childbearing, 31*, 61–75.

Barrera, M. (1981). Social support in the adjustment of pregnant adolescents: Assessment issues. In B.H. Gottlieb (Ed.), *Social network and social support.* Beverly Hills, CA: Sage.

Barret, R., & Robinson, B. (1982). A descriptive study of teenage expectant fathers. *Family Relations, 31*, 349–352.

Barth, R.P., Schinkle, S.P., & Maxwell, H. (1983). Psychological correlates of teenage motherhood. *Journal of Youth and Adolescence, 12*, 471–487.

Braen, B.B., & Forbush, J.B. (1975). School-age parenthood: A national review. *Journal of School Health, 45*, 256–262.

Brown, H., Adams, R.G., & Kellam, S.G. (1981). A longitudinal study of teenage motherhood and symptoms of distress: The Woodlawn community epidemiological project. In R. Simmons (Ed.), *Research in community mental health.* Greenwich, CT: JAI Press.

Brozan, N. (1985, March). Rate of pregnancies for U.S. teenagers found high in study. *New York Times*, section A.

Burden, D., & Klerman, L. (1984). Teenage parenthood: Factors that lessen economic dependence. *Social Work, 29*, 11–16.

Center for Population Options. (1985). *The facts of teenage sexuality, pregnancy and parenthood.* Washington, DC: Author.

Children's Defense Fund. (1988). *Model programs: Preventing adolescent pregnancy and building youth self-sufficiency.* Washington, DC: Author, p. 9.

Chilman, C.S. (1980). Social and psychological research concerning adolescent childbearing: 1970–1980. *Journal of Marriage and the Family, 50,* 793–805.

Connolly, L. (1975). Little mothers. *Human Behavior, 11,* 17–23.

Crim, A. (1987, March). *American children in poverty.* Address to the Children's Defense Fund Conference, Washington, DC., pp. 67–68.

Cvetkovich, G., & Grote, B. (1975). *Antecedents of responsible family formation.* Progress report paper presented at a conference sponsored by the Population Division, National Institute of Child Health and Human Development, Bethesda, MD.

Dillard, D.K., & Pol, L.G. (1982). The individual economic costs of teenage childbearing. *Family Relations, 31,* 249–259.

Dryfoos, J. (1985). A time for new thinking about teenage pregnancy. *American Journal of Public Health, 75,* 13.

Dryfoos, J., & Heisler, T. (1978). Contraceptive services for adolescents: An overview. *Family Planning Perspectives, 10,* 229–233.

Edelman, M.W. (1987). *Families in peril: An agenda for social change.* Cambridge, MA: Harvard University Press.

Edelman, M. (1988). Preventing adolescent pregnancy: A role for social work services. *Urban Education, 22,* 496–509.

Ensminger, M.E. (1979). *Welfare status and feelings of psychological distress.* Paper presented at American Sociological Association, Boston, MA.

Faigel, H.E. (1967). Unwed pregnant adolescents: A synthesis of current viewpoints. *Clinical Pediatrician, 6,* 281–285.

Finkel, M., & Finkel, D. (1975). Sexual and contraceptive knowledge, attitudes and behaviors of male adolescents. *Family Planning Perspectives, 7,* 256–260.

Fox, G.L. (1980). The mother-adolescent daughter relationship as a sexual socialization structure: A research review. *Family Relations, 29,* 21–28.

Furstenburg, F.J. (1969). Birth control knowledge among unmarried pregnant adolescents: A preliminary report. *Journal of Marriage and the Family, 31,* 34–42.

Furstenburg, F. (1976). *Unplanned parenthood: The social consequences of teenage childbearing.* New York: Free Press.

Furstenburg, F.F., & Crawford, A.G. (1978). Family support: Helping teenage mothers to cope. *Family Planning Perspectives, 10,* 322–333.

Goldfarb, J.L., Mumford, D., Schum, D.A., Smith, P.B., Flowers, C., & Schum, C. (1977). An attempt to detect pregnancy susceptibility in indigent adolescent girls. *Journal of Youth and Adolescence, 6,* 127–144.

Goldsmith, S., Gabrielson, M., & Gabrielson, I. (1972). Teenagers, sex and contraception. *Family Planning Perspectives, 4,* 32–38.

Grow, L.J. (1979). *Early childbearing by young mothers: A research study.* New York: Child Welfare League of America.

Hofferth, S.L., & Moore, K.A. (1979). Early childbearing and later economic well-being. *American Sociological Review, 44,* 784–815.

Hogan, D.P., & Kitagawa, E.M. (1983). The impact of social status, family structure, and neighborhood on the fertility of black adolescents. *American Journal of Sociology, 90,* 825.

Hornick, J., Doran, L., & Crawford, S. (1979). Premarital contraceptive usage among male and female adolescents. *Family Coordinator, 28*, 181–190.

Ireson, C. (1984). Adolescent pregnancy and sex roles. *Sex Roles, 11*, 189–201.

Jorgenson, S., King, S., & Torrey, B. (1980). Dyadic and social network influences on adolescent exposure to pregnancy risk. *Journal of Marriage and the Family, 42*, 141–155.

Kaplan, H.B., Smith, P.B., & Pokorny, A.D. (1979). Psychological antecedents of unwed motherhood among indigent adolescents. *Journal of Youth and Adolescence, 8*, 181–207.

Keat, D.B. (1979). *Multimodal therapy with children.* New York: Pergamon Press.

Kellam, S. (1979). *Consequences of teenage motherhood for mother, child and family in a black urban community.* Progress report to Center for Population Research. Bethesda, MD: National Institute of Child Health and Human Development.

Klerman, L.V. (1975). Adolescent pregnancy: The need for new policies and new programs. *Journal of School Health, 45*, 263–267.

Koenig, M.A., & Zelnik, M. (1982). The risk of premarital first pregnancy among metropolitan area teenagers: 1976 and 1979. *Family Planning Perspectives, 14*, 239.

Kyman, W., Berger, D., & Perez, G. (1987). The making of an adolescent clinic. *Adolescence, 22*, 879–882.

La Rue, P., & Miller, V. (1988). Helping teen parents stay in school: A case study. *Spectrum, 6*, 25–28.

Lazarus, A.A. (1981). *The practice of Multimodal Therapy.* New York: McGraw-Hill.

Lazarus, A.A. (1984). Multimodal Therapy. In R.J. Corsini (Ed.), *Current psychotherapies* (pp. 491–530). Itasca, IL: Peacock.

McCarthy, J., & Menken, J. (1979). Marriage, remarriage, marital disruption and age at first birth. *Family Planning Perspectives, 11*, 21–30.

McGee, E. (1982). *Too little, too late: Services for teenage parents. An examination of some major programs now operating in the United States to service teenage parents and their children. Including a look at the range and quality of available services and candid remarks by service providers.* New York: Ford Foundation.

Mecklenburg, M., & Thompson, P. (1983). The adolescent family life program as a prevention measure. *Public Health Reports, 98*, 21–29.

Meichenbaum, D., & Cameron, R. (1973). Training schizophrenics to talk to themselves: A means of developing attention controls. *Behavior Therapy, 4*, 515–534.

Meichenbaum, D., & Novaco, R.W. (1978). Stress inoculation: A preventive approach. In C. Spielberger & I. Sarason (Eds.), *Stress and anxiety: Vol. 5.* New York: Halstead Press.

Michaels, G., & Brown, R. (1983, August). Values of children as adolescent mothers. *Paper presented at the annual convention of the American Psychological Association* (91st), Anaheim, CA.

Miller, W.B. (1973). Concept mastery: Ego control of the psychological and behavioral antecedents to conception. *Comments on Contemporary Psychiatry, 1*, 157–177.

Millman, S.R., & Hendershot, G.E. (1980). Early fertility and lifetime fertility. *Family Planning Perspectives, 12*, 139–140.

Moore, K. (1983). *School-age parents: Federal programs and policies relevant to pregnant or parenting secondary students. Facts at a glance.* Washington, DC: The Urban Institute.

Moore, K., & Caldwell, S. (1977). The effect of government policies on out-of-wedlock sex and pregnancy. *Family Planning Perspectives, 9,* 164–169.

Moore, K., & Hofferth, S. (1978). *The consequences of age at first childbirth: Final research summary.* Washington, DC: U.S. Department of Commerce, National Technical Information Service. The Urban Institute.

Moore, K., & Waite, L. (1977). Early childbearing and educational attainment. *Family Planning Perspectives, 9,* 220–225.

Morrison, P. (1978). *Consequences of late adolescent childbearing.* Preliminary report to Center for Population Research. Bethesda, MD: National Institute of Child Health and Human Development.

Mott, F.L. (1986). The pace of repeated childbearing among young American mothers. *Family Planning Perspectives, 18,* 5–12.

National Research Council. (1987). *Risking the future: Adolescent sexuality, pregnancy and childbearing.* Washington, DC: National Academy Press.

Novaco, R.W. (1979). The cognitive regulation of anger and stress. In P.C. Kendall & S.D. Hollon (Eds.), *Cognitive-behavior interventions: Theory, research and procedures.* New York: Academic Press.

Nye, F.I. (1976). *School-age parenthood: Consequences for babies, mothers, fathers, grandparents and others.* Pullman, WA: Washington State University, Cooperative Extension Service.

O'Connell, M., & Rogers, C. (1984). Out of wedlock births, premarital pregnancies and their effect on family formation and dissolution. *Family Planning Perspectives, 16,* 157–162.

Ogg, E. (1976). *Unmarried teenagers and their children.* Public Affairs Pamphlet, No. 537. New York: Public Affairs Press.

Olson, C.F., & Worobey, J. (1984). Perceived mother-daughter relations in a pregnant and non-pregnant adolescent sample. *Adolescence, 19,* 781–794.

Planned Parenthood Poll. (1986). *American teens speak: Sex, myths, T.V., and birth control.* New York: Louis Harris & Associates.

Piotrow, P.T. (1975). Mothers too soon. *Draper World Population Fund, 1,* 3–6.

Presser, H.B. (1980). Sally's corner: Coping with unmarried motherhood. *Journal of Social Issues, 36,* 107–129.

Rader, G.E., Bekker, L.D., Brown, L., & Richardt, C. (1978). Psychological correlates of unwanted pregnancy. *Journal of Abnormal Psychology, 88,* 174–181.

Rains, P. (1971). *Becoming an unwed mother: A sociological account.* Chicago: Aldine.

Rindfuss, R.R., Bumpass, L.L., & St. John, C. (1980). Education and fertility: Implications for the roles women occupy. *American Sociological Review, 45,* 553–583.

Robbins, C., Kaplan, H.B., & Martin, S.S. (1985). Antecedents of pregnancy among unmarried adolescents. *Journal of Marriage and the Family, 47,* 567–583.

Russ-Eft, D., Sprenger, M., & Beever, A. (1979). Antecedents of adolescent parenthood and consequences at age 30. *Family Coordinator, 28,* 173–178.

Sandler, H. (1979). *Effects of adolescent pregnancy on mother-infant relationships: A transactional model*. Report to the Center for Population Research. Bethesda, MD: National Institute of Child Health and Human Development.

Scales, P., & Gordon, S. (1978). Preparing today's youth for tomorrow's family. *Journal of the Institute for Family Research and Education, 1*, 3–7.

Shah, F., Zelnik, M., & Kantner, J. (1975). Unprotected intercourse among unwed teenagers. *Family Planning Perspectives, 7*, 39.

Thompson, R.A. (1986). The unwed adolescent mother. In L.B. Golden & D. Capuzzi (Eds.), *Helping families help children*. Springfield, IL: Charles C Thomas.

Trussell, J. (1975). Early childbearing and subsequent fertility. *Family Planning Perspectives, 10*, 209–218.

Ventura, S. (1984). Trends in teenage childbearing, United States, 1970–81. (Data from the National Vital Statistics system.) *Vital and Health Statistics, 41*, 32pp.

Wilson, J. (1986). *Teen age parenting: The long term effects for mothers and children*. State, Local and Intergovernmental Center. Cambridge, MA: Harvard University.

Zabin, L. and Others. (1981). The risk of adolescent pregnancy in the first months of intercourse. In F. Furstenberg (Ed.), *Teen sexuality, pregnancy, and childbearing* (pp. 136–148). Philadelphia: University of Pennsylvania Press.

Zelnik, M., & Kantner, J. (1979). Reasons for non-use of contraceptives by sexually active women, ages 15–19. *Family Planning Perspectives, 11*, 289–294.

Appendix

Collective Resources

Information, Programs, and Funding Available for Adolescent Health Services and Pregnancy Prevention and Care Services

Child Trends, Inc.
Fact Sheet: Facts at a Glance
2100 M Street, NW
Washington, DC 20037
(202) 223-6288

Healthy Mothers/Healthy Babies Coalition
600 Maryland Avenue, SW
Washington, DC 20024
(202) 628-5577

Adolescent Pregnancy Programs
Public Health Service
Department of Health and Human Services
330 Independence Avenue, SW
North Building, Room 1351
Washington, DC 20201
(202) 245-1042

Information on Statistics and Research on Sex Education and Teenage Pregnancy

American College of Obstetricians and Gynecologists
Newsletter: *NAACOG Newsletter*
600 Maryland Avenue, SW
Washington, DC 20024–2589
(202) 638-5577 or (800) 533-8822

Center for Population Options
1012 14th Street, NW, Suite 1200
Washington, DC 20005
(202) 347-5700

The Alan Guttmacher Institute
111 Fifth Avenue
New York, NY 10003
(212) 254-5656

National Center for Health Statistics
U.S. DHHS/Public Health Services
3700 East-West Highway, Room 157
Hyattsville, MD 20782
(301) 436-8500

Information on Adolescent Pregnancy Initiatives

American Public Welfare Association
1125 15th Street, NW
Washington, DC 20005
(202) 293-7550

Grants That Support Community Education on Teenage Pregnancy and Family Programs

Charles Stewart Mott Foundation
1200 Mott Foundation Boulevard
Flint, MI 48502–1851
(313) 238-5651

Information About the Annual Florence Crittenton Roundtable on Teenage Pregnancy

Child Welfare League of America
440 First Street, NW, Suite 310
Washington, DC 20001–2085
(202) 638-2952

Information About Lobbying, Programs, and Policies That Affect Large Numbers of Children

Children's Defense Fund
122 C Street, NW
Washington, DC 20001
(202) 628-8787

Information on Courses and Programs on Adolescent Sexuality Education

The Health and Education Council, Inc.
7201 Rossville Boulevard
Baltimore, MD 21237
(301) 686-3601

Information on the Saint Paul Story: A Teaching Manual on the Pioneer School-Based Clinics

Health Start., Inc.
640 Jackson Street
St. Paul, MN 55101
(612) 221-3422

Assistance in the Development of Health Care Services for Children in Need

March of Dimes Defects Foundation
Newsletter: *Maternal Newborn Advocate*
1275 Mamaroneck Avenue
White Plains, NY 10605
(914) 428-7100

Healthy Children
641 Huntington Avenue
Boston, MA 02115
(617) 732-1407

Technical Assistance on Forming an Advocacy Network and Policy Development for Family Life Programs in Schools

The National Association of State Boards of Education
701 N. Fairfax, Suite 340
Alexandria, VA 22314
(703) 684-4000

The New Jersey Network for Family Life Education
The Center for Community Education
R. 4087—Kilmer Campus
Rutgers The State University
New Brunswick, NJ 08903
(201) 923-7929 or 923-7798

Information on Training Institutes for Family Life Educators and Curriculum Materials

Family Life Information Exchange (FLIE)
P.O. Box 10716
Rockville, MD 20850
(301) 770-3662

The National Family Life Education Network
P.O. Box 8506
1700 Mission Street, Suite 320
Santa Cruz, CA 95060
(408) 429-9822

Health Education Grants, Programs, and Collaboration

National Family Planning and Reproductive Health Association, Inc.
Newsletter: *NFPRHA News*
122 C Street, NW, Suite 380
Washington, DC 20001–2109
(202) 628-3535

The National Foundation/March of Dimes
P.O. Box 200
White Plains, NY 10602

Publications on Health Policy and Children's Issues

National Governor's Association
Hall of the States
444 North Capitol Street
Washington, DC 20001
(202) 624-5300

National Organization on Adolescent Pregnancy and Parenting, Inc.
Newsletter: *NOAPP Network*
P.O. 2365
Reston, VA 22090
(703) 435-3948

Assistance in Locating Health Information Through Identification of Health Information Resources, Referral Systems, and Free Health-Related Literature

National Health Information Clearinghouse
P.O. Box 1133
Washington, DC 20013
(800) 336-4797

Funding of Programs to Improve Access to Personal Health Care for the Most Underserved Population Groups, Particularly Adolescents

The Robert Wood Johnson Foundation
P.O. Box 2316
Princeton, NJ 08543-2613
(609) 452-8701

Bibliographies of Curricula, Texts, Audiovisual Materials, and Trade Publications for Children, Teens, Adults, Teachers, and Parents, And Subscriptions to the DIECUS Report

SHARE Resource Center on Teen Pregnancy Prevention
P.O. Box 2309
Rockville, MD 20852
(800) 537-3788

Sex Information and Education Council of the U.S., Inc.
80 Fifth Avenue
New York, NY 10011
(212) 673-3850

National Maternal and Child Health Clearinghouse
38th and R Streets, NW
Washington, DC 20057
(202) 625-8410

National Resource Center for Youth Service
University of Oklahoma
440 South Houston, Suite 751
Tulsa, OK 74127
(918) 581-2986

Data Archives on Adolescent Pregnancy and Pregnancy Prevention

Sociometrics Corporation
685 High Street
Number 2 E
Palo Alto, CA 94301
(415) 321-7846

Information on Postponing Premarital/Premature Sexual Intercourse

The Human Health Center
Saint John's University
Collegeville, MN 56321
(612) 363-3313

Why Wait
Box 1000
Dallas, TX 75221

Chapter 10

NO GUARANTEE OF IMMUNITY: AIDS AND ADOLESCENTS

Lizbeth A. Gray and Reese M. House

Joshua is a 17-year-old teenager from a typical American family. He has been diagnosed with AIDS. He contracted the virus through sexual experimentation. He has been prevented from attending school. His friends reject him. His brothers and sisters are afraid to be with him. His mother and father cry and feel helpless in the battle to keep him alive. He now weighs 86 pounds. He is often too sick to go out of the house. He will die soon. He is very frightened.

It is relatively easy to talk about high-risk groups, projected numbers, causal agents, transmission processes, and prevention strategies in an intellectual and objective manner. It is harder to speak of the fear of Joshua's death and dying process. It is difficult to embrace the pain that his family experiences as they lose someone they love. This chapter focuses on AIDS information we need to know as counselors working with adolescents. It may seem distant and removed. What we are asking readers to do is learn the information about AIDS, integrate it, and open their hearts to the anguish that AIDS is causing our society. We must learn to understand this disease with both our minds and our hearts.

Introduction

The adolescent has been identified to be at risk in areas ranging from school dropout to suicide. Since being publicly diagnosed in 1981, acquired immune deficiency syndrome (AIDS) has presented a new risk for the adolescent. This epidemic is having a tremendous social and psychological impact on modern society. AIDS can no longer be ignored.

Ramifications of this crisis are far-reaching, and there is no doubt that the health and welfare of the world's population are in jeopardy.

AIDS has claimed over 42,000 lives in the United States as of October 1988 (Centers for Disease Control [CDC], 1988) and 270,000 are expected to die from the disease by 1991 (CDC, personal communication, August 5, 1988). Of the 75,768 Americans who have been diagnosed with AIDS, 305 have been adolescents (CDC, 1988). However, this figure of less than 1% for adolescents is not cause for reassurance. Almost 25% of diagnosed AIDS cases are people in their 20s (CDC, 1988); because of the long incubation period of the virus it is likely that these individuals contracted the disease while still teenagers (Helquist, 1988). Acquired immune deficiency syndrome is now recognized as a global health problem, with 74 countries reporting the disease (Quinn, Mann, Curran, & Piot, 1986). Due to the lack of a curative therapy, this disease now ranks as the most serious epidemic of the past 50 years (Quinn et al., 1986).

Factual Information About AIDS

The cause of AIDS is believed to be a retrovirus that targets and destroys certain white blood cells essential to the functioning of the body's immune system (Levy, Hoffman, Kramer, Landis, Shimabukuro, & Oshiro, 1984). Once the immune system is severely depressed, other opportunistic infections develop that eventually cause death. After exposure to the virus some people are initially asymptomatic, whereas others develop a milder but debilitating illness called AIDS-related complex (ARC). There is no cure for AIDS. Once an individual contracts the AIDS virus, he or she is infected for life. It has been estimated that 99% of persons infected with the causative agent, human immunodeficiency virus (HIV), develop AIDS and die from AIDS-related illnesses within 5 to 10 years (CDC, personal communication, August 5, 1988).

HIV is not as contagious as other well-known viruses such as the common cold. This virus does not seem to be transmittable through casual social contact such as coughing, sneezing, shaking hands, sharing eating utensils, or using the same telephone (Oregon State Health Division [OSHD], 1986). The virus is actually fragile and is quickly killed on environmental surfaces when treated with disinfectants (OSHD, 1986). Medical authorities have repeatedly stated that transmission occurs only through three modes: sexual contact, exposure to infected blood or blood products (i.e., sharing needles, blood transfusions), and passage of the virus from a woman to her fetus or newborn infant (OSHD, 1987). In addition to the infectious blood and semen, vaginal and cervical secretions are known to contain the virus and may account for female-to-male transmission. It is thought that the vast majority of HIV-infected persons are carriers who are unaware that they have been exposed to the virus but are nevertheless capable of infecting others (OSHD, 1987). Saliva, tears, urine, cerebrospinal fluid, and feces may also contain the virus in infected persons, but have not been directly implicated in transmission of the infection (OSHD, 1987).

Since it was first reported in the United States in 1981, AIDS has occurred predominantly in the homosexual and bisexual male population, accounting for 62% of the persons diagnosed with AIDS. Other groups also at risk are: present or past intravenous (IV) drug users, recipients of infected transfused blood, heterosexual partners of AIDS-diagnosed and HIV-seropositive (the condition in which antibodies to the virus are found in the blood) persons, male or female prostitutes and their sex partners, and infants born to HIV-seropositive mothers (CDC, 1988).

In other areas of the world, however, heterosexual transmission of AIDS accounts for a majority of the cases (Quinn et al., 1986). In the United States the number of AIDS cases involving heterosexuals is increasing 100% every 6 months (Van Ness, 1987). AIDS is a problem among all races. Approximately 26% of AIDS cases in the United States, however, are among Blacks, and 15% are among Hispanics (CDC, 1988). The figures far exceed the corresponding percentages of these minority populations relative to the total population of the United States; Blacks compose 12% of the American population and Hispanics compose 6% (DiClemente, Boyer, & Morales, 1988).

The time between infection and the onset of symptoms ranges from 6 months to 5 years or longer. Most individuals infected with the AIDS virus initially have no symptoms. Others develop early symptoms such as tiredness, fever, loss of appetite and weight, diarrhea, and night sweats and swollen lymph glands, all of which are similar to the symptoms of the common cold and flu. Unlike the common cold, symptoms of AIDS are ongoing and persistent. Also, the virus frequently affects the brain and central nervous system, causing confusion or dementia. About 70% of AIDS patients eventually die from two primary infections: pneumocystis carinii pneumonia, or a type of cancer known as Kaposi's sarcoma (CDC, 1988).

Adolescents Are At Risk

Ennis (1987) predicted that by 1991 AIDS will be the number one killer of youth, exceeding the number of deaths resulting from automobile accidents. The basis for this projection can be attributed to a number of factors. Foremost, adolescents are highly sexually active.

> By age 15, 16 percent of boys and 5 percent of girls in the United States have had heterosexual intercourse at least once. By age 17, these rates almost triple for boys and increase 5 times for girls. By age 19 three quarters of all boys and almost two thirds of all girls have been sexually active. ("AIDS and the Education," 1988, p. 5)

One survey estimated that as many as 700,000 young men may have at least 10 sex partners a year, putting them at considerable risk of sexually transmitted diseases including AIDS (Byrd, 1988).

Second, teenagers who are sexually active do not make a practice of using condoms and spermicides, which help prevent the spread of all sexually transmitted diseases, including AIDS. Adolescents between the ages of 10 and 19 constitute 25% of gonorrhea and syphilis cases ("AIDS and the Education," 1988). Only half of sexually experienced adolescents use any form of contraception at first intercourse, whatever the age of the first sexual experience (Alan Guttmacher Institute, 1981).

Third, it has been reported that female adolescents contract AIDS more frequently than adult women (Helquist, 1988). This may be due to the unique anatomic and physiological structure of teenagers.

> Differences in ovarian function and differences in the cervical milieu in young adolescents may facilitate entry and spread of certain organisms. . . . The adult pH (concentration level of acid) is more protective against the invasion of some organisms associated with venereal diseases. (Hein, 1987, p. 293)

In addition to these physiological factors, evidence shows that most adolescents do not seek health care on a regular basis, thereby increasing the chance that AIDS may go undetected (Ennis, 1987).

Also increasing the adolescent's risk for AIDS is the high percentage of teens who have tried drugs or who use drugs on a regular basis. "Over half of high school seniors have used illicit drugs, though only a small percentage of teenage drug users use intravenous drugs and risk contracting AIDS in this way" ("AIDS and the Education," 1988, p. 5). Illicit substances are known to impair the immune system, contributing to susceptibility for contracting AIDS. Use of alcohol or drugs such as amphetamines (speed), amyl nitrite (poppers), cocaine, and marijuana impair judgment and increase the chances of risky or dangerous sexual behaviors.

Some adolescents experiment sexually with the two groups of people known to be at highest risk, homosexual/bisexual men and intravenous drug users; thus, a bridge or chaining effect is established for transmission of the virus to the larger teenage population (Hein, 1987). As a result, teenagers are most likely to contract AIDS from such chained heterosexual contact, rather than direct homosexual contact or intravenous drug use (Helquist, 1988).

Due to the high frequency of sexual activity, failure to use condoms and spermicides, physiological factors, inadequate health care, drug involvement, and the chain effect resulting from experimentation with homosexual contact, teenagers are particularly vulnerable to contracting AIDS. Consequently, it is urgent that the counseling professional consider the implications of the AIDS epidemic when treating adolescents. The counselor must not only keep in mind the high risk to this population, but also the unique characteristics and developmental processes that are the hallmarks of adolescents. For example, teenagers are beginning to form their own independent identities, values, and life-styles. As a professional, one cannot separate AIDS from other life issues. Thus, working with adolescents in the age of AIDS must be done in a comprehensive fashion and in the context of the adolescent's developmental phase of growth.

Response of Teens

Panic and hysteria are common responses to AIDS among adolescents. When understanding this psychological phenomenon, it is critical to recognize that parental attitudes affect the way children think. Often parental attitudes about AIDS, based in part on lack of knowledge and fear of homosexuality, manifest themselves through their teenagers.

The adolescents' anxiety of contracting a deadly disease through sexual activity is heightened by embarrassment and lack of knowledge about sexual intimacy, which are both common to the normal developmental processes of adolescents. One 1986 study found that nearly 80% of adolescents in San Francisco were anxious about AIDS, but had little knowledge about how to avoid the infection (DiClemente, Zorn, & Temoshok, 1987).

On the other hand, many adolescents exhibit a lack of concern or denial with respect to the AIDS epidemic, believing that they are invulnerable. In a study of 250 high school students aged 16 to 19, 73% responded that they were not worried about getting AIDS (Price, Desmond, & Kukulka, 1985). This belief in personal invulnerability, particularly in relationship to health issues, is an intrinsic developmental feature of adolescents.

Most people judge their risk level by imagining a stereotype of who will be involved in a negative event such as contracting AIDS (Weinstein, 1980, 1984; Bauman & Siegel, 1987). People associate AIDS with homosexuals and distance themselves from the possibility of contracting AIDS because they do not fit the stereotype. Weinstein (1984) labeled this as unrealistic optimism. One author found, after surveying a group of children, that they had a fairly accurate understanding of AIDS and possible modes of transmission. However, there was such a strong association with homosexuality that it obscured any sense of direct threat to themselves (Belfer, 1986).

Of 860 randomly selected adolescents, 70% indicated that they were sexually active. More than half stated that they did not worry at all about contracting AIDS. Only 15% said they had changed their sexual behavior because of concern about AIDS, and of this group, only one in five used effective methods of protection (Strunin & Hingson, 1987). Further evidence supporting this position can be found in a recent study of 150 undergraduates that showed that 81% were sexually active. More than 60% of these sexually active students reported having had sexual intercourse during the previous year without using a condom, even though they were knowledgeable about the risks of contracting AIDS (Gray & Saracino, 1988).

The Roles of the Counselor

The counselor needs to undertake multifaceted roles in the battle against AIDS. No singular approach will be effective. The different roles include, but are not limited to: sex educator, networker and advocate, therapist, specialist for the harder-to-reach youth, and referral agent. It is important for the counselor to be aware and knowledgeable of the coexisting and sometimes conflicting responsibilities inherent in these roles. Most important is the recognition that counselors are obligated, by the mere nature of being a part of the helping profession, to actively participate in the battle against AIDS. Counselors are in a pivotal position to prevent the further spread of AIDS in the adolescent population as agents of change in schools, churches, community agencies, government agencies, treatment centers, and private practice. In order to do so, however, the counselor must be knowledgeable and competent in the following areas:

1. Counselors must be comfortable addressing sexuality from a variety of perspectives in order to perform the role of sexual educator effectively.
2. Counselors must be willing to assume the responsibility of providing information about AIDS by implementing age-appropriate curricula in their setting.
3. Counselors must be aware of the networking and advocacy role they need to take in communities, schools, and with parents.
4. Counselors must know how to counsel the sexually active teen and family, the worried-well teen and family, as well as the youth diagnosed with AIDS and family.
5. Counselors must understand the special needs of harder-to-reach youth, such as the runaway, minority teen, substance abuser, and gay adolescent.
6. Counselors must assume the role of referral agent by knowing available community, state, and national resources.

The Counselor as Educator

In the absence of an effective treatment or vaccine against HIV infection, educational programs in risk reduction must continue to be developed to restrict the spread of AIDS in the adolescent population (Koop, 1986). The incidence of new AIDS cases among gay men has plateaued since intense educational campaigns were undertaken in the gay community. This phenomenon indicates that individuals in this high-risk group are becoming educated and, as a result, are willing to change their sexual practices. The goal of counselors should be education and behavioral change for *all potentially and currently sexually active people.* The ultimate goal is an AIDS incidence rate of zero. The intent is to eradicate AIDS in the same manner that society has eradicated other epidemics. The best weapon we have in this battle is education.

It is critical for counselors to expand their definition of counseling by accepting the responsibility for providing this education about AIDS. Education may be done in the schools, in treatment centers, in governmental agencies, in community programs, or in whatever milieu teenagers are found. As AIDS educators, counselors need to be concerned with their own comfort in working with sexual issues and be involved in the development and implementation of creative AIDS curricula.

Counselor comfort. Effective AIDS interventions require that the educator be comfortable talking about sexual issues. No matter how carefully organized AIDS curricula and outreach strategies are, the embarrassed or fearful sex educator can inadvertently sabotage AIDS prevention efforts. Sexual comfort is the most important qualification of a professional sex educator. Counselors are part of the larger American society that typically receives inaccurate sexual information and powerful negative messages about sexuality. This inaccurate information and the negative messages about sexuality impede the professional from talking comfortably about sex.

Communication about sexual issues is frequently made difficult by the profound emotional impact that sexual vocabulary carries. Confusion also arises because sexual terms lack precision. Consequently, not only is effective communication diminished but also the sex educator may transfer negative emotional feelings to the adolescents with whom he or she works.

It is erroneous to assume that counselors have developed sexual comfort as part of their training. A recent survey of 270 counselor education programs indicated that only 44% offered individual sexual counseling courses. The majority of courses were not required. No counselor education program surveyed indicated that sexual training for counselors was overemphasized (Gray, Cummins, Johnson, & Mason, 1989). Thus, the counselor's readiness to conduct AIDS education with adolescents is hampered by societal influence and lack of specific sexual training.

Becoming sexually comfortable is an ongoing process that is circular in nature. In order to be able to educate about sexual issues, one must develop personal sexual awareness and comfort. The sexually uncomfortable person sets an awkward professional atmosphere that invites inhibition. Conversely, success as a sex educator contributes to a positive self-concept. In order to work with adolescents and AIDS, the counselor must consciously begin the process of increasing his or her own sexual comfort. This journey begins by actively addressing the following factors that are likely to contribute to physical, mental, or emotional constraint in the role of sex educator:

1. Inaccurate sexual knowledge;
2. Lack of an explicit sexual vocabulary;
3. Limited practice in talking about sex;
4. Lack of identification and resolution of personal sexual issues; and
5. Sexual values and biases that interfere with openness to alternative life-styles for others.

AIDS curricula. The counselor should take the lead in implementing AIDS curricula in the school and community. Helping professionals have been reticent regarding the subject of sex for too long. It would be a grave mistake for counselors to continue to ignore sexual issues and AIDS in working with adolescents. An equally serious mistake would be to overreact and fail to handle these issues in a professional and holistic manner.

The United States Surgeon General, Dr. C. Everett Koop, ("AIDS and the Education," 1988) has specifically called for schools to stop avoiding frank discussions about sex and start teaching children about AIDS and its dangers at the lowest grade possible. Adolescents must be told that if they are infected with the virus they will eventually die. They must also be explicitly informed about which sexual behaviors put them at risk and which are safer. The responsibility of the counselor is to effectively deliver information about AIDS and safer sex practices, while at the same time helping individuals legitimize healthy sexual options.

Most state health departments have developed AIDS curricula for youth unique to the values and concerns of each geographical area. It is important that the counselor familiarize himself or herself with the local curricula as well as national educational models. To achieve optimum effectiveness, AIDS risk-reduction programs should include information that is age-specific and geared toward adolescents' own needs, perceptions, fears, and concerns. It is suggested that AIDS education be part of a larger educational framework. For example, in a school setting such information could be included in a communicable disease unit or health education unit that can be taught as a part of a comprehensive K–12 health education curriculum. Curricula may be viewed as six separate, yet interfacing, content areas that include medical information, risky and safer sexual behavior, common myths and misinformation, effective sexual decision-making skills, effective sexual communication skills, and safer sex plans. Tables 1 through 6 present examples of the content that can be included in these topical areas.

The Counselor as Networker and Advocate

In the role of networker and advocate, the counselor must be knowledgeable about the particular political issues the AIDS crisis poses. Typical political problems include lack of funding for research and social services, community values that prevent or thwart education about sexual issues, and religious and moral views that reject alternative life-styles or sexual behaviors.

Some individuals believe that AIDS information should not be taught in schools because it will take time away from conventional aspects of the school curriculum. Others believe that promotion of safer sex behaviors will encourage sexual activity among adolescents. Even others say that sex education belongs only in the home and not in the community or school. It is safe to say that opinions are polarized regarding AIDS education for adolescents. All too evident is that some individuals have

TABLE 1

AIDS Curricula: Medical Information

The most recent medical information about AIDS including cause, acquisition, treatment, and prevention must be a part of the curricula. The questions delineated in items 1–6 are ways to approach the topical areas that should be covered when educating adolescents about AIDS.

1. What is acquired immune deficiency syndrome (AIDS)? AIDS is a disorder of the immune system where the immune system is weakened and is unable to prevent life-threatening infections.
2. How is AIDS transmitted? The AIDS virus is spread by sexual contact, needle sharing, or less commonly through tainted transfused blood or its components. The virus also may be transmitted from infected mother to infant during pregnancy, birth, or shortly after birth through breast feeding.
3. How is AIDS not transmitted? AIDS is not spread by casual contact such as: hugging, kissing, holding hands, touching objects handled by an infected person, toilet seats, dishes, telephones, etc.
4. Who can get AIDS? Anyone who has sex with an infected person or who shares needles is at risk. This risk is increased by having multiple sexual partners.
5. Is there a test for AIDS? A blood test can usually identify the presence of antibodies to the AIDS virus. Testing procedures are improving and becoming more accurate. Controversy exists regarding the reliability of the test, who should be tested, and how the results should be handled. Consult your local AIDS project or state health division for the latest information.
6. Is there treatment for AIDS? There is no cure or treatment for AIDS. Treatments for the associated infections that AIDS invites are experimental; regardless of intervention, everyone diagnosed with AIDS is expected to die.

an intense emotional investment in their value position about AIDS and sex education.

Therefore, it is important as a networker and advocate to take into consideration the basic fundamentals of organizational change. The counselor must become familiar with the power structure of the community and lines of decision making within specific agencies or programs. Effective community involvement can make a difference between success and failure in addressing AIDS issues in each community. For example, it is important that all points of view be represented before and during the development of an intervention program. This can be done in part by seeking participation from members of the community

TABLE 2

AIDS Curricula: Risky and Safer Sexual Behavior

It is important to include the latest available information about risky and safer sexual behavior. Educating adolescents in terms of the dangerous-to-safe continuum identified below using straightforward language is essential.

1. *Dangerous behaviors include:* vaginal and anal intercourse without a condom, oral-anal contact (rimming), putting a hand or fist into vagina or anus (fisting), fingers, tongue, or penis touching the vagina during menstruation, sharing sex toys (e.g., vibrators), piercing the skin, sharing needles.
2. *Risky behaviors include:* oral sex on a man without a condom, oral sex on a woman, masturbation on open/broken skin.
3. *Less risky behaviors include:* vaginal intercourse with a condom*, wet kissing, anal intercourse with a condom, oral sex without a condom (as long as ejaculation doesn't take place in the mouth), urinating on unbroken skin.
4. *Safer behaviors include:* dry kissing if neither person has open cuts or sores, masturbation on healthy skin, oral sex on a man with a condom, touching, masage, fantasy, parallel masturbation, clothed body to body rubbing, voyeurism, exhibitionism.
5. *The safest behavior is abstinence from sexual contact.* Solitary masturbation and other individual sexual practices may be considered as options.

***Use of the condom:** It is only with the proper use of a condom that the transmission of the AIDS virus can be prevented. Condoms can break or slip off during sexual intercourse. There is a correct procedure for applying a condom. It is important to put the condom on the penis prior to any sexual contact. Applying the condom includes squeezing and holding the end of the condom while unrolling it over the entire erect penis. The man must withdraw the penis while still erect to prevent the condom from slipping off and leaking. Condoms must not be reused. Latex condoms are effective barriers against the virus; natural animal skin condoms are not effective. Extra protection is provided by latex condoms that have spermicidal jelly containing nonoxynol-9. If additional lubrication is used it is important to avoid oil-based lubricants such as vaseline, mineral oil, or cold cream. Oil-based lubricants can erode and create holes in the condom. A recommended option is the water-based lubricating jelly, K-Y.

---

who represent diverse populations and who may disagree about the need for AIDS education. Utilizing a needs assessment model will help in understanding the specific needs of a given community.

Additionally, networking with other educators who have successfully addressed these issues in the community will provide a basis for

TABLE 3

AIDS Curricula: Common Myths and Misinformation

It is critical for the educator to dispel these common myths and misinformation about AIDS and any other myths that are common to adolescents.

1. Only homosexuals get AIDS.
2. Only the sexually promiscuous get AIDS.
3. Donating blood can result in AIDS.
4. Casual contact such as touching, sneezing, having a meal with/sharing eating utensils with someone who has AIDS, and sharing a bathroom or going to the same school with a person with AIDS can transmit the virus.
5. AIDS can be transmitted through saliva, sweat, and tears.
6. Alcohol and drugs do not increase the risk of contracting AIDS.

strategic planning. This contributes to the development of a program that is acceptable to the community and yet meets the educational needs of the adolescent. When talking with community members about AIDS, it is important to correct their misunderstandings by providing the most current and accurate information. It is important to use statistics that speak specifically to the community in which the counselor is working. Communities, families, and individuals, confused or anxious about AIDS, deserve the help of professionals versed in handling the struggles surrounding this sensitive issue.

Many national, state, and local resources provide current information. A list of these resources is provided at the end of this chapter. To become an advocate who will be effective in addressing the AIDS and adolescents issue in your community, the following steps are suggested:

1. *Create an AIDS resource center for adolescents in your school, agency, or community*. The center should provide articles, pamphlets, books, and lists of local resources. Contact health departments, existing centers in other communities, or AIDS hotlines to find out what is available. Invite reputable guest speakers to discuss the social and medical aspects of AIDS and their effect on families and adolescents. Such speakers may be contacted through existing AIDS organizations and health departments in each community. The resources and informational talks provided by the center typically are appropriate not only for adolescents and their families, but also for any professional staff that would benefit from continuing education.

TABLE 4

AIDS Curricula: Sexual Decision-Making Model

Effective sexual decision-making skills need to be taught in terms of a larger frame of personal values. The exercise below is one example of a decision-making model for adolescents.

Check any of the reasons listed below that you used in deciding to become involved in a specific sexual behavior:

______ I wanted to find out what it felt like.
______ I was sexually excited.
______ I wanted to be as experienced as my friends are.
______ I was talked into it.
______ I didn't really decide—it just sort of happened.
______ I felt it would make me feel more mature or adult.
______ My partner and I decided we were ready for it.
______ I felt it was about time I tried it.
______ My parents said it would be okay.
______ Other: ____

Check any of the reasons listed below that you used in deciding not to participate in a specific sexual behavior:

______ I was scared.
______ I didn't really like the person.
______ My parents would disapprove.
______ I wasn't sure how to do it.
______ I don't believe people my age should be doing that.
______ I wanted to wait until I was in love.
______ I was afraid of getting caught.
______ My partner wouldn't agree to it.
______ I was afraid of getting venereal disease.
______ I was afraid of getting AIDS.*
______ I was afraid it would result in pregnancy.*
______ Other: ____

From *About Your Sexuality* (p. 19) by D. Calderwood. © 1983, Boston: Beacon Press. Adapted by permission.

*Entries by chapter authors.

2. *Voice concern to officials of organizations about the need to develop policies about AIDS and adolescents.* Schools, businesses, and government agencies have developed, or are in the process of developing, policies and procedures on AIDS. Offer your opinions regarding the special needs of adolescents to any organization that should be concerned

TABLE 5

AIDS Curricula: Sexual Communication Skills

Effective sexual communication skills are critical. Listed below are several areas that need to be talked about with a prospective partner prior to a sexual relationship.

1. Feelings.
2. Significance of the sexual encounter.
3. Sexual preferences and needs.
4. Birth control methods.
5. Safer sex plans.

with the AIDS issue. This may involve writing or speaking to legislators, school board members, presidents of corporations, and other officials.

3. *Support adolescents with AIDS and their families.* In many cases, individuals have been mistreated by friends and families after being diagnosed with AIDS. Some have been denied medical and social services. As a mental health professional it is necessary to be supportive and understanding when listening to each individual's worries and needs. Communicate to everyone concerned that one does not contract AIDS through casual contact, and that touching and emotional support are critical for the adolescent with AIDS.

4. *Develop awareness of AIDS resources in your community and encourage and support the implementation of additional needed resources.* The health care needs of those with AIDS are placing severe pressures

TABLE 6

AIDS Curricula: Safer Sex Plans

Sexually active adolescents might be encouraged to consider this current safer sex protocol. These guidelines are conservative and are presented as a framework that can be negotiated and modified to meet the particular needs of each individual adolescent.

1. Talk with prospective partner about sexual history.
2. Consider taking the HIV antibody test if sexual history warrants.
3. Commit to a monogamous relationship.
4. Refrain from exchange of bodily fluids for 6 months if there have been previous sexual contacts.
5. After 6 months use a condom with spermicidal jelly nonoxynol-9 when engaging in activities where there is exchange of bodily fluids.
6. Be informed about what specific sexual behaviors are dangerous, risky, less risky, safer, and safe.

on the health care system. It is important to know what resources exist in your community and to assist in the development of needed services. By assisting in fund-raising drives, starting a local AIDS support group, or calling local resources to see what is lacking, the counselor can promote the well-being of the adolescent population in the community. This active participation encourages others to become involved in providing much needed community support services.

The Counselor as Therapist

For the counselor as therapist, there are two broad adolescent groups that warrant attention. The first group includes two populations: adolescents whose behavior is curently high risk, and teenagers who may be concerned and anxious but whose behavior is not high risk. (This second population is often referred to as the "worried-well.") The second group includes adolescents who have AIDS. In addition to being knowledgeable in all the aspects of AIDS and sexuality that were previously defined for the counselor in the roles of sex educator and networker/advocate, the therapist needs to consider incorporating the following guidelines into the counseling session:

1. Provide information about AIDS to youth and their families.
2. Address the difficulties of implementing safer sex plans.
3. Respond to the emotional and psychological confusion surrounding sexual behaviors.
4. Incorporate exploration about sexual decision making.
5. Utilize counseling techniques such as role-play so that the client can rehearse discussing sexual behavior with prospective partners.
6. Assist the adolescent client in exploring personal sexual values in order to come to terms with similarities and differences between self and family of origin.
7. Refer the adolescent client to community resources for assistance with problems related to being concerned about AIDS.

Hypothetical Dialogue With a Worried-Well Youth

The following are sections of a hypothetical case dialogue between a school counselor and an adolescent. The above guidelines are incorporated into the responses to the client.

1. *Information*

Client: I saw on television last night this show about people dying from AIDS. I'm sure glad I'm not gay.

Counselor: I'm glad that you are concerned. However, AIDS is not a disease of only the gay population; anyone can get AIDS. If a person is sexually active, they need to protect themselves by using condoms. (The counselor could provide a pamphlet with more information about AIDS and teens.)

2. *Safer sex plan*

Client: Forget it. I'm not using condoms—they are too stupid.

Counselor: At first it is hard to use condoms. What is stupid about them for you? (The counselor and client could then discuss safer sex practices, keeping in mind that the less behavior the counselor asks a client to change, the more likely the behavior change is to occur. The key question is: "What is the least amount of change that you can make that will protect you from being at risk for AIDS?")

3. *Emotional confusion*

Client: I know that I shouldn't be sleeping with Pam, but it feels so good to be held.

Counselor: All of us need to be touched. If sex is making you feel bad, are there other ways you can be close to Pam? (A discussion might follow of the confusion that often exists between emotional closeness and sexual activity.)

4. *Decision making*

Client: Some of the boys don't put up with a girl who doesn't go all the way. I don't know what to do because I have heard so much about AIDS.

Counselor: Making these decisions is not easy. It would be great if there were a right answer that I could give you. What is most important is to help you decide which sexual activities feel comfortable and right for you. (The counselor might want to use the decision-making model included in this chapter.)

5. *Sexual values*

Client: My mom thinks that I shouldn't be Johnny's friend because she says he's a "homo." But, I like him better than any of the other kids in my class.

Counselor: It sounds like you and your mom have a difference in values. Sometimes people that we care about believe differently than we do. (This might lead into a discussion of values and self-confidence.)

6. *Referral*

Client: I don't know quite how to tell you this, but I am worried that I might have AIDS. Last week I slept over at Jim's house and we messed around.

Counselor: I appreciate your honesty. I have the name of a community clinic that kids can go to and get more information about AIDS.

Everything there is kept confidential. Would you like to talk more about your concerns?

Counseling Diagnosed Youth

Counseling the AIDS-diagnosed youth takes sensitivity and skill. The youth who has AIDS is facing a life-threatening illness, inevitable death, and stigmatization by some individuals in society. The client is likely to be confused about the medical aspects of the disease and guilt-ridden about past sexual experiences or drug use. The emotional responses of the client will also include fear, anger, denial, pain, and regret.

The specific guidelines suggested in Table 7 are one model of how to work with the adolescent with AIDS. It is important to remember that the suggested steps are not linear, and emphasis depends on the individual client and the relationship with that particular client. The therapeutic issues center around helping clients find the personal strength to cope with the remainder of their life. One of the most important aspects of counseling with the dying is a therapist's willingness to just "be there." The therapist is not able to take the pain or loss away from the clients. It is their pain and they will suffer it. Over and over again, dying persons indicate they fear being abandoned (Kalish, 1981). Because people with AIDS are frequently abandoned by loved ones and stigmatized by society, it is particularly important to interact with the client with great compassion, consistency, and genuineness. Without these fundamental dimensions, the following steps become empty rhetoric.

Case Study of an AIDS-Diagnosed Youth

The following is an example of how the therapist might begin to respond to an AIDS client like Joshua, the 17-year-old who was introduced at the beginning of this chapter. The guidelines from Table 7 are used as the framework for the therapist's responses.

Joshua is a frail, yet bright-eyed, 17-year-old White adolescent who was diagnosed with AIDS 3 months ago. He currently lives with his family. The initial counselor-client contact took place in the home upon recommendation of his physician. His parents are confused, yet supportive of his need for counseling. His presenting problem was: "Please help me—I don't want to die."

TABLE 7

Guidelines for Counseling the AIDS-Diagnosed Youth

A. Assessing
    1. Degree of medical illness
    2. Degree of psychological stress
    3. Degree of social isolation—support systems
    4. Significant others and family responses
    5. Management of daily living
    6. Financial need

B. Educating
    1. Effects of the virus
    2. Awareness of health care issues
    3. Transmission of the virus
    4. Sexual expression options

C. Assisting
    1. Networking with social agencies
    2. Employment and housing needs and discrimination
    3. Developing support systems

D. Counseling
    1. Providing an emotionally caring atmosphere
    2. Confronting denial about the AIDS diagnosis
    3. Confronting rejection and stigma issues
    4. Addressing loss and grieving issues surrounding death
    5. Teaching stress identification and reduction techniques

E. Advocating
    1. Social
    2. Political
    3. Legal

Joshua is the oldest of five children. He has three brothers aged 15, 14, and 12 and one sister aged 11. All members of the family have been active members of the Catholic church and the children attend Catholic schools. Father is 45 years old and works in middle management in a high-tech corporation. Mother is 43 years old and works part-time as a librarian in the state library. Joshua describes a history of happy family vacations and frequent outings until his preteen years. More recently the family has experienced financial stress and subsequent withdrawal of father due to more time spent at work. In the absence of his father Joshua has taken over the role of second parent to the younger children. The family members seem to operate more independently from one another than in the past.

Joshua was a well-liked student in high school until his diagnosis. His friends have been abusive to him and have not visited with him since his diagnosis. He was active in sports and extracurricular activities. He dated frequently and had occasional sexual contact; Joshua had many female friendships prior to his diagnosis. Approximately 1 year ago, accompanied by two peers, Joshua had a sexual encounter with two prostitutes.

Joshua's grades ranged between C+ and B−. He had started his senior year of high school, but due to negative community reaction was not able to finish the first semester after his diagnosis became public. Joshua used to work part-time at the library, but has been unable to work because of his illness.

Joshua had no significant medical history other than normal childhood illnesses prior to his diagnosis. Currently, he is recovering from a bout of pneumocystis pneumonia after spending 2 weeks in the hospital. He is still on medication for the pneumonia. Over the past 6 months he has lost 52 pounds. He is now at home and improving each day, though he currently weighs only 86 pounds. He has not been able to go outside the home for over a month.

Joshua seemed agitated, restless, and was unable to make eye contact for long periods of time. During the initial contact with the counselor he was teary-eyed, admitted great fear, and expressed confusion and helplessness. He struggled to maintain his composure throughout the session. He was reluctant to talk about his sexual history, though he seemed willing to relate other information about his past. He expressed bitterness toward his family and friends for abandoning him.

Therapist's Response

Assessing. Joshua is seriously ill but it can be expected that he will soon go into remission and feel better for periods of time. His psychological stress is high; his core issues seem to be fear of death and abandonment as well as guilt about his sexual contact(s). Currently, his support systems are not strong. However, possibilities for support exist from the parental dyad, from siblings, and from former friends. The theme of responses to Joshua are rejection and helplessness. Joshua's daily needs are being met. He currently is receiving consistent health care, and his basic living needs are being provided by his parents. The family's financial situation prior to the illness was tenuous and is further stretched by the high medical costs associated with AIDS.

Educating. It is important that Joshua, his family, and other individuals who are part of his system understand the cycle of AIDS and its related infections. The family and Joshua need accurate information about the effects of the medication so that they can distinguish between the medical effects and the symptoms of the infections associated with AIDS. If he and others are educated about the course of the virus, they will be able to make the most of the times when he is feeling better. Because there is a connection between the body's physiological responses and health habits, it is imperative that he eat and sleep well. Joshua and his family and friends need to have accurate information about how the HIV virus is transmitted. In particular, they need to understand the myths about AIDS transmission through casual contact. One reason for Joshua's rejection may be due to this kind of misinformation.

Assisting. It will be essential to work with community agencies that can provide outside assistance for Joshua. These include the local AIDS project and the county and state health departments. Frequently, support groups exist for persons with AIDS, and volunteers are available to help with transportation and other practical needs. This kind of intervention would give Joshua opportunities to leave the house occasionally. The issues of medical expenses for the family and future hospitalization also need to be addressed through the appropriate agencies. The counselor might need to get involved in outreach contacts to the other boys who also had sexual contact with the prostitute. It is likely that these adolescents are anxious and worried about contracting AIDS themselves.

Efforts need to be made to help Joshua continue his part-time employment at the library, even if in a more limited way. This might include arranging for Joshua to be allowed to bring library work home to do. The school needs to be contacted and a plan initiated so Joshua can continue in his high school program. The special services of the school district should be identified and contacted. Tutoring to assist Joshua to gain his high school diploma may be a viable option.

Joshua's primary, although not fully functioning, support system is his family. Family meetings should be held to work with the withdrawal patterns of his brothers and sister, the distancing of his father, and the helplessness of his mother. It might be important for the family to understand the caretaker role Joshua played as oldest sibling in the family, and the possible fear of family members associated with the prospect of losing that caretaker. The parents in particular will need to come to terms with the stigma associated with having a child who has AIDS. The family members must be assisted in recognizing the critical part they can play in supporting Joshua.

Other potential support systems are the many female friends Joshua had and athletic teammates at school. These two groups would need special outreach efforts to reestablish positive relationships.

Counseling. In starting a counseling relationship with Joshua, the counselor must be emotionally caring and supportive. The first step in the process is to assist Joshua in expressing his emotions in a safe and nonjudgmental setting. Joshua is experiencing denial and anger and must eventually be confronted with these issues in a facilitative manner. In order to confront Joshua about these issues it is essential to create a trusting bond. The pain associated with abandonment and rejection by his family and friends must be processed. The counselor can help Joshua begin to face his death by encouraging him to grieve and deal with his many losses. Because research has suggested that increase in the stress level exacerbates the rate of HIV-related infections, the therapist is obligated to teach stress identification and stress reduction techniques. If at all possible, it is important for the counselor to continue the therapeutic relationship with Joshua until his death.

Advocating. As in the landmark case of Ryan White (who contracted AIDS as a child from blood transfusions and was not allowed to continue enrollment in school in Kokomo, Indiana), Joshua may need social, political, and legal advocacy to help him fight the likely social injustices that affect adolescents with AIDS. The counselor needs to be proactive with all of the community agencies to ensure that Joshua receives the care and treatment to which he is entitled. It is imperative that the counselor take the necessary action and contact various agencies such as social security, legal aid, and the schools.

Ethical Issues in Counseling With the AIDS Client

The development of AIDS and the resulting deaths raise several professional questions for the counselor. A primary concern is confidentiality limits with the AIDS client who continues to be sexually active without informing his or her partner. The question that has recently been debated is: "At what point, if any, do counselors breach a confidential relationship with a client who has the AIDS virus to preserve society's goals of health and safety?" (Gray & Harding, 1988, p. 219). Limits of confidentiality in the counseling relationship have previously been defined in terms of "clear and imminent danger" (American Association for Counseling and Development [AACD], 1988, Section D.4) to self or others, ordinarily seen in the context of client suicide and homicide.

Ethical standards do not precisely define what is clear and imminent danger. Therefore, the counselor does not necessarily know when it is appropriate to take responsibility for the client and break confidentiality. Clients who have AIDS and continue to be sexually active without informing their sexual partner(s) present a dilemma for professionals. Counselors are currently debating this controversy over the limits of confidentiality. However, the ethical standards do obligate the counselor to consult with other professionals whenever possible. Counselors who find themselves struggling with the conflict between confidentiality guidelines and clear and imminent danger guidelines should consult with other professionals as a part of their decision-making process.

Gray and Harding (1988) suggested that as a last resort when working with uncooperative clients, the therapist directly notify known sexual partners. With unknown sexual partners, these authors suggest that counselors consult with public health authorities and use state-identified procedures for responding to a client behaving dangerously. This ethical dilemma highlights the fine line between individual freedom and the health and welfare of society at large. There is no dominant legal precedent to look to for guidance on this issue, and it is likely that statutes will vary from state to state. Frequently statutes are at odds with ethical guidelines. This presents yet another complication for the therapist working with the adolescent who is not informing partners of his or her AIDS diagnosis.

Working With the Special Needs of Harder-to-Reach Youth

Whereas adolescents within the mainstream of the school system can benefit from traditional school-based AIDS education, adolescents outside the system need to be reached through specially targeted programs. The harder-to-reach adolescent often is the poor student, the drug abuser, the gay youth, and the minority teen. Adolescents in these groups are frequently kicked out of their homes because their family doesn't have money to support them or because their parents cannot handle them. They drop out of school, run away, and end up as street kids. About 30% of all students will drop out of high school before graduation, and more than one million teenagers run away each year (Center for Population Options as cited in Hersch, 1988). These runaways are escaping stressful environments and most often are victims of dysfunctional families. It is a myth that adolescents run away to seek adventure and excitement.

> 36 percent run from physical and sexual abuse; 44 percent from other severe long-term crises such as drug abusing, alcoholic parents or stepfamily crisis; and 20 percent from short-term crisis such as divorce, sickness, death, and school problems. . . . Approximately 70 percent of the runaways who come to the emergency shelters have been severely physically abused or sexually molested. (Hersch, 1988, p. 31)

Street kids have been labeled the "throwaways." These adolescents are sexually active with many people. It is a way to fight loneliness, satisfy curiosity, and survive hunger and homelessness. They are at increased risk for AIDS by virtue of lack of information regarding HIV infection, high level of drug use, and resorting to prostitution to earn money. HIV screening on these "throwaway" youth shows that approximately 18% have positive test results ("Throwaway Youths," 1988).

A recent figure indicates that an overwhelming number, over 200,000 teenagers, are involved in prostitution (Center for Population Options as cited in Hersch, 1988).

> They go home and sleep with their [old] friends, they sleep with their parents, they sleep with each other—there is hardly anybody they don't sleep with. And, of course, they sleep with their johns, who sleep with their wives and who also may be sleeping with their kids and their secretaries. (Able-Peterson as cited in Hersch, 1988, p. 35)

Gay men are currently and have always been the number one high risk group for AIDS in the United States. It is generally thought that 10% of the adult population is gay; that means 1 out of every 10 children in a classroom will eventually identify as gay (Heron, 1983). The gay youth is constantly pressured into a male-female life-style by a society that assumes everyone is heterosexual. It is not surprising that gay youth have become one of the biggest subgroups that make up the street kid phenomenon. The pain and fear of struggling with sexual identity creates a lonely world not often shared with anyone. If the adolescents' gay orientation is known, they often lose their family and peer group support system.

Counselors must challenge their own heterosexual assumptions. They must make a conscious effort to look for the children in the classroom who are grappling with sexual identity issues. It is important to listen to these children in a nonjudgmental fashion and help them find support in their struggle. The counselor must help the gay youth face two major issues: isolation and rejection by family. Through proactive and supportive interventions, such as acknowledgment that homosexuality is an acceptable life-style, it may be possible to meet the needs of these children. Consequently, this may prevent some from becoming runaways.

The minority teen is also at high risk for contracting AIDS, as indicated by the percentage of Blacks and Hispanics who have been diagnosed. The minority youth needs special attention and educational efforts. According to DiClemente et al. (1988):

> Black and Latino adolescents demonstrate a greater likelihood of perceived susceptibility. The prevalence of misconceptions about the threat of casual contagion of AIDS among Black and Latino adolescents suggests the need for preventive AIDS education not only to decrease potential high-risk behaviors, but also to reduce unnecessary feelings of anxiety regarding susceptibility. (p. 57)

Conventional programs discussed in the curricula section earlier in this chapter will not be effective for the harder-to-reach youth. For example, many of the conventional educational programs are not written in the language of the minority group. Emphasis needs to be placed on outreach programs that move outside of the classroom and into the streets. Counselors must be creative and develop programs using whatever methods work to reach these teenagers. If the kids can't come to counselors, counselors must go to the kids. Workers from programs for runaway children in New York City cruise the streets until 5:00 a.m. each morning offering hot chocolate, sandwiches, and condoms. The language counselors use may need to be changed. Terms such as intercourse and oral sex may need to be thrown out the window for "fucking" and "sucking." Along with professionalism, the therapist must bring his or her own "street smarts" when talking to the kids if high risk behavior for AIDS is going to be changed.

The Counselor as Referral Agent

The process of referral can be used in a variety of circumstances. The first may be when the counselor recognizes that his or her own biases and values are interfering with delivering appropriate services. At this time it is critical for the counselor to make the referral in a manner that does not negatively affect the adolescent with AIDS or the adolescent who has concerns about AIDS. A second reason for referral may arise when a problem is so specialized that it requires unique assistance that the counselor cannot provide. A third reason for referral is when a professional deems that his or her training and background are not appropriate to address the issue of AIDS.

It is important for the mental health professional to be familiar with existing resource lists or how to find them. In general, national helping professional organizations provide guidance for locating appropriate resources. The Center for Population Options (1012 14th Street, N.W., Suite 1200, Washington, DC 20005, (202) 347-5700) is a primary AIDS and adolescents resource at the national level. The center provides bibliographies, curricular information, pamphlets, materials for parents, videos, and leader resources.

State and local professional organizations also provide direction. *Typically, state and community health departments have current information about AIDS and should be considered a major information source.* In addition, organizations that specifically focus on providing AIDS services are available in most large communities. Included in the appendix of this chapter is a list of national organizations specifically involved in responding to the AIDS epidemic, and an AIDS bibliography.

Future Directions

Researchers are currently struggling to acquire the information and medical technology needed to develop a cure for AIDS. The outlook for a cure in the near future is not optimistic; but, as this medical fight continues, counselors must be involved actively in the social, psychological, political, legal, and ethical ramifications of AIDS. Adolescents with AIDS have been labeled by some as the modern-day lepers. This severe social stigma placed on adolescents with AIDS cannot be tolerated.

Counselors have special talents that can contribute to changing the course of negative societal reactions and eventually the course of this epidemic. By working actively to provide education and therapeutic intervention, the helping professional can assist individuals and their families in coping with the ravages of this disease. It is critical to unite with social workers, psychologists, physicians, health care providers, researchers, lawyers, government workers, religious leaders, and civic groups to address all ramifications of AIDS.

Helping professionals are not powerless. The ability to help others change their behavior, and to provide and foster compassion and concern for those diagnosed with AIDS, places counselors in a position of great influence. Helping others to change high-risk behavior so that the rate of AIDS infection is slowed would be a legacy of counselors worth remembering.

In this chapter we have emphasized the importance of counselors, accepting the role of educator. Education means more than providing factual information. It would be a grave mistake to assume that factual information by itself translates into behavioral change. The counselor must be progressive and creative. We need to break through the adolescent myth of: "This won't happen to me." One way to do this is to challenge the misconception that only homosexuals and IV drug users contract AIDS.

It is of paramount importance to promote media that depict the danger to heterosexuals. When adolescents see a peer die they will begin to relate to the risk AIDS poses to all adolescents.

References

AIDS & the education of our children. (1988). Consumer Information: U.S. Department of Education, pp. 5–35.

Alan Guttmacher Institute. (1981). *Teenage pregnancy: The problem that hasn't gone away.* New York: Author.

American Association for Counseling and Development. (1988). *Ethical standards.* Alexandria, VA: Author.

Bauman, L.J., & Siegel, K. (1987). Misperceptions among gay men of the risk for AIDS associated with their sexual behavior. *Journal of Applied Social Psychology, 17*(3), 329–350.

Belfer, M.L. (1986). *Psychological impact of AIDS on children.* (Report No. PS 015879). Cambridge, MA: Harvard Medical School at Cambridge Hospital, Department of Child Psychology. (ERIC Document Reproduction Service No. ED271211).

Byrd, R. (1988, September 23). 10 or more sex partners a year puts thousands of men at risk. *Corvallis Gazette-Times,* p. A2.

Calderwood, D. (1983). *About your sexuality.* Boston: Beacon Press.

Centers for Disease Control. (1988, October 17). *AIDS Weekly Surveillance Report.* Atlanta: Author.

DiClemente, R.J., Boyer, C.B., & Morales, E.S. (1988). Minorities and AIDS: Knowledge, attitudes, and misconceptions among Black and Latino adolescents. *American Journal of Public Health, 78,* 55–57.

DiClemente, R.J., Zorn, J., & Temoshok, L. (1987). The association of gender, ethnicity, and length of residence in the bay area to adolescents' knowledge and attitudes about acquired immune deficiency syndrome. *Journal of Applied Social Psychology, 17,* 216–230.

Ennis, T. (1987, Spring). Prevention of pregnancy among adolescents. Part 1: The schools' role. *School Law Bulletin,* pp. 1–15.

Gray, L.A., Cummins, E.J., Johnson, B., & Mason, M. (1989). Human sexuality instruction in counselor education curricula. *Counselor Education and Supervision, 28*(4), 305–317.

Gray, L.A., & Harding, A.K. (1988). Confidentiality limits with clients who have the AIDS virus. *Journal of Counseling and Development, 66,* 219–223.

Gray, L.A., & Saracino, M. (1988). *The knowledge and behavior of selected undergraduate students with respect to AIDS.* Manuscript submitted for publication.

Hein, K. (1987, May). AIDS in adolescents: A rationale for concern. *New York State Journal of Medicine,* pp. 290–295.

Helquist, M. (1988, June). The Helquist report. *Advocate,* p. 37.

Heron, A. (Ed.). (1983). *One teenager in ten: Writings by gay and lesbian youth.* Boston: Alyson Publications.

Hersch, P. (1988). Coming of age on city streets. *Psychology Today*, pp. 28–34.

Kalish, R.A. (1981). *Death, grief, and caring relationships*. Monterey, CA: Brooks/Cole.

Koop, E. (1986, October). *Surgeon General's report on acquired immune deficiency syndrome*. U.S. Department of Health and Human Services, Public Health Service.

Levy, J., Hoffman, A., Kramer, S., Landis, J., Shimabukuro, J., & Oshiro, L. (1984). Isolation of lymphocytopathic retroviruses from San Francisco patients with AIDS. *Science, 225*, 840–842.

Oregon State Health Division. (1986). *Oregon Health Division's guidelines for AIDS in the workplace*. Portland: Department of Human Resources.

Oregon State Health Division. (1987). *AIDS: Epidemiology and control information for Oregon physicians*. Portland: Department of Human Resources.

Price, J.H., Desmond, S., & Kukulka, G. (1985). High school students' perception and misperceptions of AIDS. *Journal of School Health, 55*, 107–109.

Quinn, T.C., Mann, J.M., Curran, J.W., & Piot, P. (1986). AIDS in Africa: An epidemiologic paradigm. *Science, 234*, 955–962.

Strunin, L., & Hingson, R. (1987). Acquired immunodeficiency syndrome and adolescents: Knowledge, beliefs, attitudes, and behaviors. *Pediatrics, 79*, 825–828.

"Throwaway youths: A world of crack, prostitution and AIDS." (1988). *Behavior Today, 19*(39), p. 6.

Van Ness, P. (1987, November). *CDC Update on AIDS*. Paper presented at the Fourth Annual Conference on School-Based Clinics, Kansas City, MO.

Weinstein, N.D. (1980). Unrealistic optimism about future life events. *Journal of Personality and Social Psychology, 39*(5), 806–820.

Weinstein, N.D. (1984). Why it won't happen to me: Perceptions of risk factors & susceptibility. *Health Psychology, 3*(5), 431–457.

Appendix 1

National Organizations Involved in AIDS Issues

AIDS Action Council, 729 Eighth Street S.E., Suite 200, Washington, DC 20003; (202) 547-3101. This national organization works with the federal government to create a sound national AIDS policy, and lobbies for funding of AIDS research and treatment. It represents more than 300 community-based organizations that provide direct services to people with AIDS.

American Association of Physicians for Human Rights (AAPHR), 2940 16th Street, Room 309, San Francisco, CA 94103; (415) 558-9353. AAPHR is a national organization of physicians and medical students that deals with medical issues affecting homosexual men and women. Although not specifically an AIDS organization, AAPHR releases position statements about AIDS issues such as national mandatory antibody testing, and airline discrimination against PWAs. It also runs a national referral service for physicians and patients.

American Foundation for AIDS Research (AmFAR), 5900 Wilshire Blvd., 2nd Floor—East Satellite, Los Angeles, CA 90036; (213) 857-5900; and 40 West 57th Street, Suite 406, New York, NY 10019; (212) 333-3118. AmFAR is a private, national not-for-profit organization providing funding for research into the cure, prevention, and treatment of AIDS. It also produces educational materials for the general public, medical and scientific professionals, and PWAs.

The American Red Cross, 17th and D Streets N.W., Washington, DC 20006; (202) 737-8300. (Consult your phone book for your local chapter.) The objective of the American Red Cross is to slow the spread of AIDS through information and education that encourages responsible behavior. It provides training and educational materials for minorities and the general public for use in schools and the workplace, as well as other forms of support to people with AIDS, their families, and people testing HIV-positive. Contact your local chapter, not the national office, for these materials.

Computerized AIDS Information Network (CAIN), a service of the Gay and Lesbian Community Service Center, 1213 N. Highland Ave., P.O. Box 38777, Hollywood, CA 90038; (213) 464-7400, Ext. 277. This computer database provides AIDS information to subscribers 24 hours a day. The network receives 5,000 articles each month; the information is constantly updated. Listings in CAIN are free of charge. The network also allows people with AIDS to communicate with one another anonymously via computer.

Mothers of AIDS Patients (MAP), P.O. Box 3132, San Diego, CA 92103; (619) 293-3985 or (619) 576-6366. MAP was started by three mothers who lost children to AIDS. It offers emotional support to families of people with AIDS, provides information about the disease, and assists people with AIDS who have been rejected or are isolated from their families. It gives referrals and support by phone or mail.

National AIDS Network (NAN), 2033 M Street, N.W., Suite 80, Washington, DC 20036; (202) 293-2437. The National AIDS Network consists of community-based AIDS organizations, hospitals, and educational facilities. It provides technical assistance, referral services, and grants to its member organizations.

National Association of People With AIDS, 2025 Eye Street, N.W., Suite 415, Washington, DC 20006; (202) 429-2856. NAPWA is an association of local organizations by and for people with AIDS. It is based on the philosophy of self-empowerment. The association provides information and referrals to its member organizations and also advocates for rights for people with AIDS. It has more than 60 affiliates, and over 6,000 members.

National Coalition of Gay Sexually Transmitted Disease Services (NCGSTDS), P.O. Box 239, Milwaukee, WI 53201; (414) 277-7671. The coalition was established to encourage information exchange among gay STD and AIDS service providers; its members are primarily health care professionals. Funds are raised through membership dues and subscriptions to its publicaton.

National Council of Churches AIDS Task Force, 475 Riverside Dr., Room 572, New York, NY 10115; (212) 870-2421. Preventive education is the focus of this group. It has compiled a resource and information packet for use by religious leaders in their congregations.

National Leadership Coalition on AIDS, 1150 17th Street, N.W., Suite 202, Washington, DC 20036; (202) 429-0930. More than 100 corporations, businesses, and religious, labor, trade, and health organizations make up this coalition, which seeks to increase public and private sector cooperation on AIDS issues. It is working especially to improve the response of employers and employees to AIDS, and to encourage balanced and informed consideration of public policies concerning the disease.

Appendix 2

Annotated Bibliography

Advice for Life: A Woman's Guide to AIDS Risks and Prevention. Chris Norwood. Pantheon Books. ISBN 0-394754-28-X. $7.95. Discusses transmission, symptoms, and personal prevention by explaining high-risk activities and which men may be at high risk for AIDS. Also addresses "the caring woman" and her role in the epidemic, and the future of AIDS.

AIDS: A Catholic Call for Compassion. Eileen P. Flynn. Sheed & Ward. ISBN 0-934134-73-1. $4.95. Discusses AIDS from a Catholic perspective. Points the way beyond fear to reason and concern.

AIDS: The Facts. John Langone. Little, Brown. ISBN 0-316-51412-8. $8.95. Explains in clear, concise language how the AIDS virus works, how it is transmitted, and why, based on the latest scientific knowledge and statistics. Examines in detail all the methods presently under development for treatment, as well as the possibilities for a vaccine.

AIDS: Personal Stories in Pastoral Perspective. Earl E. Shelp, Ronald H. Sunderland, and Peter W.A. Mansell. Pilgrim Press. ISBN 0-8298-0739-X. $7.95. Provides information about AIDS, its effect on both patients and nonpatients, the response of society, and the obligation of the church.

AIDS: A Self-Care Manual. Betty Clare Moffatt et. al. IBS Press. ISBN 0-9616605-1-1. $12.95. A comprehensive self-care guide, created by the AIDS Project Los Angeles, that examines the many aspects of personal AIDS management. The manual is a valuable resource for people with AIDS and AIDS-related illnesses, as well as for health professionals, therapists, caregivers, ministers, medical writers, family members, spouses, co-workers—everyone touched by the AIDS crisis.

AIDS: The Spiritual Dilemma. John E. Fortunato. Harper & Row. $7.95. Encourages a spiritual response to society's victimizing attitude. Stresses the importance of a spiritual journey to help transcend the crisis.

AIDS: You Can't Catch It Holding Hands. Niki de Saint Phalle. Lapis Press. ISBN 0-932499-52-X. $6.95. This remarkable and unique book for children (or a charming book to dispel adults' fears and introduce them to the problem) provides a clear understanding of the latest information about AIDS, and refocuses our attention on the positive aspects of human relationships.

And the Band Played On: Politics, People and the AIDS Epidemic. Randy Shilts. St. Martin's Press. ISBN 0-312-00994-1. $24.95. By the time America woke up to the dangers of the AIDS epidemic with the revelations of Rock Hudson's affliction, the disease had spread to every corner of the nation. America faced troubling questions: What went wrong? Although not without its errors in fact, this is a book that will astound and enrage any American.

Borrowed Time: An AIDS Memoir. Paul Monette. Harcourt Brace Jovanovich. ISBN 0-15-113498-3. $18.95. The extraordinary love story of two men battling AIDS together. Newsweek calls it "a powerful account of shattering eloquence."

Confronting AIDS: Directions for Public Health, Health Care and Research. Institute of Medicine/National Academy of Sciences. National Academy Press. ISBN 0-309-03699-2. $24.95. A committee with an impressive breadth of credentials was established to prepare this in-depth report. Although often technical, much information is of importance to lay audiences interested in helping to combat the epidemic.

Epidemic of Courage: Facing AIDS in America. Lon G. Nungesser. St. Martin's Press. ISBN 0-312-01560-7. $7.95. The author, who himself has AIDS, talks with seven PWAs about the impact the disease has had on their lives. He goes on to talk with a lover, a mother, a brother, a health care provider, and a friend about the crises they've suffered while working with and loving PWAs.

Living With AIDS: Reaching Out. Tom O'Connor. Corwin Publications. ISBN 9-93856-00-7. $18.95. O'Connor looks at how people with AIDS and ARC can improve the quality of their lives—even prevent further immune deterioration—and how those who test positive for the AIDS antibody can keep the prospect of disease at bay.

Making It: A Woman's Guide to Sex in the Age of AIDS. Cindy Patton and Janis Kelly. Sparks/Firbrand Books. ISBN 0-932379-32-X. $3.95. Two AIDS activists and journalists address a critical question: How can women—heterosexual, lesbian, bisexual—enjoy full sexual lives and protect themselves from AIDS? Pro-sex in tone, often humorous, with information on safe sex, pregnancy, testing, and drug use in both English and Spanish.

Night Kites. M.E. Kerr. Harper & Row. ISBN 0-694-05616-2. $2.75. A novel for young adults about a 17-year-old whose well-ordered life begins to fall apart as he keeps secret his brother's diagnosis with AIDS. How people hide, betray, accept, and love is sensitively explored in this novel.

Questions and Answers on AIDS. Lyn Frumkin and John Leonard. Avon Books. ISBN 0-380-75467-3. $3.95. Straightforward, practical advice on AIDS: what causes it, how it is transmitted, and the treatments presently available. A good introductory book on the subject.

Safe Sex: The Ultimate Erotic Guide. John Preston and Glenn Swann. Plume/NAL. ISBN 0-452-25896-0. $8.95. A certified sexual health consultant, John Preston, and "Mr. Safesex," Glenn Swann, offer the reader an explicit program of safe sexual practices for gay men and everyone concerned about AIDS.

Screaming Room. Barbara Peabody. Avon Books. ISBN 0-380-70345-9. $3.95. A mother's journal of her son's struggle with AIDS. A true story of love, dedication, and courage told with directness and feeling.

Serenity: Challenging the Fear of AIDS. Paul Reed. Celestial Arts. ISBN 0-89087-506-5. $5.95. Reed offers coping strategies that can help anyone who is struggling to find peace of mind, mental energy, and emotional balance in the midst of the pain and anguish that living with the AIDS epidemic can bring.

Sex, Drugs and AIDS. Oralee Wachter. Bantam Books. ISBN 0-553-3445-4. $3.95. Based on the 18-minute award-winning film directed toward teenagers, this book dispels the myths of how AIDS is transmitted and provides young people with ways to safeguard themselves. Although written for teenagers, this is an excellent introductory book for anyone concerned about AIDS.

Someone Was Here: Profiles in the AIDS Epidemic. George Whitmore. New American Library. ISBN 0-4530-0601-9. $27.95. This gripping account of the AIDS crisis provides intimate, moving portraits of the people with AIDS, their loved ones, and their caretakers.

Teaching AIDS: A Resource Guide on Acquired Immune Deficiency Syndrome. Marcia Quackenbush and Pamela Sargent. Network Publications. A guide for teachers that gives practical, straightforward advice on how to teach students about AIDS.

When Someone You Know Has AIDS: A Practical Guide. Leonard J. Martelli et al. Crown Publishers. ISBN 0-317-52879-3. $9.95. An informative, compassionate guide offering realistic advice about everything from fear and grief to health insurance and wills. How do you manage the medical, legal, and financial issues? Where do you find organizations that will offer support? This practical guide is used by a number of social service organizations.

Appendix 3

A Phone Directory of Local and State Organizations

This listing, compiled with the cooperation of the National AIDS Network, will help you get started if you want to volunteer your time to an AIDS group in your community. This is not a complete listing of AIDS organizations, but the groups listed here can tell you about other organizations in your area. In addition to these groups, your local, county, or state health department often can be helpful.

Phone numbers in italics are hotlines offering general information about AIDS, referrals, and sometimes counseling. Other listings are general office numbers.

ALABAMA

Birmingham: AIDS Outreach, 205-930-0440; *800-445-3741*
Mobile: AIDS Buddy Program, 205-476-9142;
AIDS Coalition, 205-344-5684
Montgomery: AIDS Outreach, 205-284-2273
Tuscaloosa: West Alabama AIDS Network, 205-345-0067

ALASKA

Anchorage: Alaska AIDS Project, 907-276-4880; *800-478-AIDS*

ARIZONA

Phoenix: Arizona AIDS Project, 602-277-1929
Tucson: AIDS Project, 602-322-6226; *602-326-AIDS*

ARKANSAS

Little Rock: ARK. AIDS Foundation, 501-224-4020; *501-374-5503*

CALIFORNIA

Bakersfield: AIDS Task Force, 805-328-0729
Berkeley: Gay Men's Health Collective, 415-644-0425
Campbell: Aris Project, 408-370-3272
Concord: Diablo V Community Church, 415-827-2960
Fresno: Central Valley AIDS Team, 209-264-2437
Garden Grove: AIDS Response Program, 714-534-0862
Guerneville: Face to Face, 707-887-1581
Irvine: Buddhist AIDS Project, 213-859-5536
Long Beach: Project Ahead, 213-439-3948
Los Angeles: AIDS Project, 213-380-2000; 213-876-AIDS
Merced: AIDS Support Team, 209-385-7709

Modesto: Stanislaus Community AIDS Project, 209-572-2437
Oakland: AIDS Project of the East Bay, 415-420-8181
Palm Springs: Desert AIDS Project-CCCC, Inc., 619-323-2118
Redding: North State AIDS Project, 916-225-5252
Sacramento: AIDS Foundation, 916-448-2437
San Diego: AIDS Assistance Fund, 619-543-0300;
 AIDS Project, 619-543-0300
San Francisco: AIDS Foundation, 415-864-4376, *800-FOR-AIDS*,
 Shanti Project, 415-777-2273
San Luis Obispo: AIDS Task Force, 805-549-5540
Santa Barbara: Tri-Counties AIDS Project, 805-681-5120
Santa Cruz: AIDS Project, 408-458-4999
Santa Rosa: Sonoma County AIDS Project, 707-527-2247
West Hollywood: AIDS Project, 213-876-8951;
 Shanti Foundation, 213-273-7591

COLORADO

Denver: Colorado AIDS Project, 303-837-0166

CONNECTICUT

Bantan: N.W. Conn. AIDS Project, 203-482-1596; *203-567-4111*
Hartford: Gay/Lesbian Health Collective, 203-236-4431
New Briton: AIDS Project, 203-225-7634; 203-225-6789
New Haven: AIDS Project, 203-624-2437

DELAWARE

Wilmington: Delaware Lesbian and Gay Health Advocates AIDS Co.,
 302-652-6776

DISTRICT OF COLUMBIA

Washington: Whitman Walker Clinic, 202-332-5295

FLORIDA

Daytona Beach: DARE, 904-257-4028
Ft. Lauderdale: AIDS Center One, 305-561-0316; *800-325-5371*
Key West: AIDS Help Inc., 305-296-6196
Lakeland: Polk AIDS Support Service, 813-665-7071
Miami: Health Crisis Network, 305-326-8833; *305-634-4636*
Orlando: Cent. Fla. AIDS Unified Resources Inc., 305-849-1452
Sarasota: AIDS Support, 813-951-1551
Tampa: AIDS Network, 813-221-6420; 813-221-6420

GEORGIA

Athens: AIDS Support Group, 404-546-0737
Atlanta: AIDS Atlanta, 404-872-0600; *800-551-2728*
Macon: Central City AIDS Network, 912-742-2437
Savannah: First City Network, Inc., 912-236-CITY

HAWAII

Honolulu: Life Foundation, 808-924-2437
Kailua: Hawaii Council of Churches, 808-263-9788
Volcano: AIDS Helpline, 808-967-7202

IDAHO

Boise: Idaho AIDS Foundation, 208-345-2277

ILLINOIS

Belleville: Helping Hands of So. Ill., 618-234-9365
Champaign: Champaign AIDS, 217-351-2437
Chicago: AIDS Education Project, 312-908-9191;
    AIDS Foundation, 312-525-9466

INDIANA

Evansville: AIDS Resource Group, 812-423-7791
Fort Wayne: AIDS Task Force, 219-484-2711
Indianapolis: AIDS Task Force, 317-634-1441

IOWA

Des Moines: Cent. Iowa AIDS Project
Iowa City: Iowa Center for AIDS/ARC Education, 319-351-0140
Waterloo: AIDS Coalition of Northeast Iowa, 319-234-6831

KANSAS

Topeka: Kansas AIDS Network, 800-247-4101;
    AIDS Project, 913-232-3100
Witchita: AIDS Project, 316-267-1852

KENTUCKY

Lexington: AIDS Crisis Taskforce, 696-281-5151
Louisville: Comm. Health Trust, 502-636-3341

LOUISIANA

Baton Rouge: MCC-AIDS Project, 504-387-4424
New Orleans: NO/AIDS Task Force, 504-891-3732

MAINE
Portland: AIDS Project, 207-774-6877

MARYLAND
Baltimore: H.E.R.O., 301-685-1180
Rockville: Montgomery County HERO, 301-762-3385
Silver Spring: African Center AIDS Project, 301-622-0129

MASSACHUSETTS
Boston: AIDS Action, 617-437-6200
Brighton: Project Win, 617-783-7300
Cambridge: AIDS Family Support Group, 617-491-0600

MICHIGAN
Detroit: AIDS Phone Network, 313-567-1640
Ferndale: PWA Food Bank, 313-864-3740
Grand Rapids: AIDS Task Force, 616-956-9009
Hamtramck: Friends, People With AIDS Alliance, 313-365-2450

MINNESOTA
Minneapolis: Minn. AIDS Project, 612-870-7773

MISSISSIPPI
Jackson: Mississippi Gay Alliance, 601-353-7611

MISSOURI
Columbia: MID Missouri AIDS Project, 314-875-2437
Kansas City: Good Samaritan Project, 816-561-8784
Springfield: AIDS Project/Springfield, 417-864-8373
St. Louis: Effort For AIDS, 314-531-2847

MONTANA
Billings: AIDS Support Network, 406-252-1212

NEBRASKA
Omaha: Nebraska AIDS Project, 402-342-4233
Project Concern/AIDS Coalition, 402-455-3701

NEVADA
Las Vegas: Aid for AIDS of Nevada, 702-369-6162
Reno: Nevada AIDS Foundation, 702-329-2437

NEW HAMPSHIRE

Concord: New Hampshire Buddy System, 603-880-6560
Manchester: N.H. AIDS Foundation, 603-880-6560

NEW JERSEY

Neptune: AIDS Information Group, 201-758-0077
New Brunswick: AIDS Education, 201-992-5666
Newark: N.J. Lesbian & Gay AIDS Awareness, 201-596-0767
Randolph: Interfaith AIDS, 201-895-4874
Vineland: Casa Prac, Inc., 609-692-2331

NEW MEXICO

Albuquerque: New Mexico AIDS Services, 505-266-0911

NEW YORK

Albany: AIDS Council, 518-434-4686
Bridgehampton: East End Gay Org., 516-537-2480
Bronx: Pediatric AIDS Hotline, 212-430-4227
Brooklyn: AIDS Task Force C.S.P., 718-596-4781
Buffalo: Western N.Y. AIDS Prog. 716-847-2441
Johnson City: So. Tier AIDS Program, Inc., 607-798-1706
New York: Gay Men's Health Crisis, 212-807-6604
Richmond Hill: AIDS Center, 718-575-8855
Rochester: AIDS Rochester, Inc., 716-232-3580
White Plains: Mid-Hudson Valley AIDS Task Force, 914-993-0606

NORTH CAROLINA

Asheville: Western N.C. AIDS Project, 704-252-7489
Charlotte: Metrolina AIDS Project, 704-333-2437
Durham: Lesbian & Gay Health Project, 919-683-2182
Greensboro: Triad Health Project, 919-275-1654
Greenville: Eastern Regional AIDS Support, 919-355-4568
Raleigh: AIDS Control Program, 919-733-7301
Wilmington: Grow AIDS Resource Project, 919-675-9222
Winston-Salem: AIDS Task Force, 919-723-5031

OHIO

Akron: AIDS Task Force, 216-375-2960
Canton: AIDS Task Force, 216-489-3231
Cincinnati: Ambrose Clement Health Clinic, 513-352-3139
Cleveland: Health Issues Task Force, 216-621-0766
Columbus: AIDS Task Force, Inc., 419-243-9351
Youngstown: AIDS Task Force, 216-742-8700

OKLAHOMA
Oklahoma City: Oasis Community Center, 405-525-AIDS

OREGON
Eugene: Willamette AIDS Council, 503-345-7089
Portland: Cascade AIDS Project, 503-223-5907
Oregon AIDS Task Force, 503-226-6678

PENNSYLVANIA
Allentown: AIDS Service Center, 215-435-4616
Altoona: AIDS Intervention Proj., 814-946-5411
Chester: American Red Cross, 215-874-1484
Harrisburg: So. Central AIDS Assistance Network, 717-236-4772
Lancaster: AIDS Project, 717-394-3380; 717-394-9900
Philadelphia: Action AIDS, 215-732-2155;
AIDS Task Force, 215-545-8686
Pittsburgh: AIDS Task Force, 412-363-6500
Reading: Berks AIDS Health Crisis, 215-375-2242
Scranton: North East AIDS Council, 717-342-4562

RHODE ISLAND
Providence: Project AIDS, 401-277-6545

SOUTH CAROLINA
Columbia: Carolina AIDS Research and Education, 803-777-2273

SOUTH DAKOTA
Sioux Falls: Sioux Empire Gay & Lesbian Coalition, 605-332-4599

TENNESSEE
Chattanooga: Chattanooga Cares, 615-265-2273
Knoxville: AIDS Response, 615-523-2437
Memphis: Aid to End AIDS Committee, 901-454-1411
Nashville: Nashville Cares, 615-385-1510

TEXAS
Austin: AIDS Services, 512-458-AIDS
Dallas: AIDS Resource Center, 214-521-5124
El Paso: SW AIDS Committee, 915-533-6809, 915-541-4266
Houston: AIDS Foundation, 713-623-6796
San Antonio: AIDS Foundation, 512-733-1853

VERMONT

Burlington: Vermont Cares, 802-863-2437

VIRGINIA

Charlottesville: AIDS Support Group, 804-979-7714
Norfolk: Tidewater AIDS Crisis Taskforce, 804-423-5859
Richmond: AIDS Information, 804-355-4428

WASHINGTON

Seattle: Northwest AIDS Foundation, 206-329-7923;
AIDS Action Committee, 206-323-1229

WISCONSIN

Milwaukee: AIDS Project, 414-273-2437

Chapter 11

"I DON'T WANT TO LIVE": SUICIDAL BEHAVIOR

Dave Capuzzi and Douglas R. Gross

The adolescent at risk for suicidal preoccupation and behavior has become an increasing concern for schools and communities throughout the United States. The topic of adolescent suicide has been a major focus for newspaper features, television specials, and legislative initiatives as the problem of adolescent suicide has reached epidemic proportions (Hafen & Frandsen, 1986). Estimates such as "7,000 teenagers each year commit suicide, while an additional 400,000 try unsuccessfully to end their own lives" (Hafen & Frandsen) are based on incomplete data (Curran, 1987) yet provide the basis for ranking suicide as the second leading cause of death among the 11-to-24 age group. According to some experts (Hafen & Frandsen), one teenager attempts suicide every 90 seconds and one completes the act of suicide every 90 minutes.

Understanding the Causes

The Adolescent Transition

Adolescence as a stage in psychosocial development has become more complex, more stressful, and more prolonged than ever before. Choices about whether to use drugs, to join gangs, to experiment sexually, or to pursue a vocational or academic course of study must be made earlier and earlier amidst escalating pressure and confusing options. These choices prove to be difficult even for adolescents who are successfully mastering the essential developmental task of separation and identity formation. These developmental tasks can occur only, however, when children and adolescents have been exposed to positive adult models for parenting and nurturing. As adults become increasingly focused on earning a living in a country in which the cost of food, clothing, housing, medical care, and other necessities has increased more rapidly than salaries, less time may be available for parenting roles. In addition, adolescents become disillusioned when political and religious luminaries (e.g., Dan Quayle, John Tower, Jim and Tammy Bakker) lose credibility because of their behavior or societal prejudice. Traditional values may seem questionable and increasing emphasis on education, which lengthens preparation time for jobs or careers that may not provide the quality of life enjoyed by today's adults, may make it even harder for adolescents to develop needed perspective. For some adolescents the use and abuse of alcohol and other substances, running away, dropping out of school, developing eating disorders, sexual acting out, and other at-risk behaviors may be connected with the need to lower stress and may be preludes to increased vulnerability for a suicide attempt or completion.

Family Dysfunctions

As mentioned earlier, the transition from childhood to adolescence and young adulthood is difficult at best. A stable, functional family can provide the support and the role modeling to make such a transition easier. Many theorists and researchers (Bigrar, Gauthier, Bouchard, & Jasse, 1966; Jacobziner, 1965; McAnarney, 1979; Otto, 1972; Truckman & Connon, 1962; Capuzzi & Golden, 1988) discuss family dysfunction as a characteristic of the family of a suicidal adolescent. Events such as divorce, death, unemployment, or moving are frequent occurrences in American families that must be dealt with in a way that promotes problem solving and good communication. Individuals in functional family systems can usually make the adjustments necessary to cope constructively with changes in the family. Members of dysfunctional families, however, usually experience high stress during periods of transition.

A number of patterns can be observed in dysfunctional families that can affect an adolescent's vulnerability to depression and suicidal preoccupation (Capuzzi, 1986).

Poor communication skills. In most families of adolescents who have attempted or completed suicide, communication between parents or between parents and children (and usually both) has not been optimal. Family members may have difficulty describing their thoughts and their feelings or be uneasy about sharing them even if they are able to articulate accurately. Usually the parents in such a family (one or both) have not been able to role model well for their children; indeed, the parents may not have experienced positive role modeling in their families of origin.

Parents may have been taught to suppress self-expression or may have been subjected to bursts of anger with little explanation or description provided. Children and adolescents usually do not attain communication levels higher than those of their parents. They may be unable or afraid to express themselves, and parents may have little awareness of the tribulations an adolescent son or daughter experiences. Often, families do not have time to share with one another, or they make such opportunities difficult because the attention of family members is directed toward a television show, a newspaper, or music even when they are all together.

Resistance to the grieving process. Loss is something that requires a grieving and adjustment process that passes through a series of phases or stages. The dissolution of the family of origin because of death or a divorce, changes in health status or job security, or moves to new housing or a new community require major psychological adjustments and changed perspectives. It is important to integrate and later reframe such experiences in a way that can lead to new beginnings and changed life-styles. Often suicidal adolescents come from families that have experienced losses and in which individual family members have resisted the need to grieve and denied the range of feelings that accompany the grieving process. Such a family can become even more dysfunctional and can increase the vulnerability of family members who already experience difficulty coping on a daily basis. Such families may not realize the need to grieve and the universality of such a need. They may not understand the range of feelings they are experiencing and attempt to deny or distort the experience and the events connected with it.

Difficulties with single parenting. The role of the single parent in American society is difficult. Escalating responsibility, lowered income, high stress, and lack of time are only a few examples of the kinds of problems a single parent may encounter. It is difficult for even the most functional of adults to cope with the parameters of raising a child (or children) without the emotional support and financial assistance a partner can provide. There may be little time for relaxation, fun, and positive verbal encounters in the life of a single parent who is having great difficulty coping with expectations and obligations. Parent-child-relationships in such a situation are bound to be impaired, and a troubled single parent is likely to be faced with a troubled adolescent.

Confusion in a blended family. When two adults who have custody of the children from a previous marriage decide to form a new family, the dynamics of the family constellation can become complex. For some adolescents, it is too difficult to adjust to a "substitute" parent for the one lost through a divorce, a new set of guidelines for behavior and discipline, additional siblings, and less personal space or a different home in a new neighborhood or community. Parents may need to arrange for family counseling when adolescent children show signs of depression and poor adjustment to the new family group.

Midlife transition stressors. Adolescence, particularly early adolescence, is a time of rapid psychological and physical change. Many parents do not realize that their adolescent children are being called upon to cope with changes as numerous and as rapid as the changes these children experienced during the first year of life. Parents may not realize that they need to spend as much or more time with their children than ever before because adolescent children look more like young adults than children in need of support, structure, and guidelines. Because parents of adolescents are usually between the ages of 35 and 50, they may be focused on assessing themselves as personalities, as partners, as career achievers, and as income providers. Often such parents, particularly parents whose own dysfunctions inhibit their perspective and their parenting abilities, fail to understand the needs of their adolescent children and do not provide the time and the structure and stability so necessary for optimal family functioning. Such parents may be too focused on their own status and too apprehensive about time "running out" to respond to the needs of their adolescent sons and daughters. It is usual for middle-aged adults to assess their satisfactions as well as their disappointments; this process, however, cannot be so consuming that members of the family lack the nurturance and psychological bonding so necessary for the rites of passage that take an adolescent successfully into the next stage of young adult development.

Abusive interactions. Families in which physical or sexual abuse is occurring or in which substance abuse is problematic may be at high risk for adolescent suicide. Parents who are abusive of each other, themselves, or their children are typically low in self-esteem, stressed, poor communicators and problem-solvers, and financially distressed. Children of such parents have not been taught to feel good about themselves and to solve problems well. During adolescence, escaping the pain of such a family atmosphere or the self-deprecating viewpoint they have probably developed may become adolescents' most predominating motivation for suicide.

Environmental Pressures

Academic achievement. Schools and families often pressure their adolescent students/children to emphasize scholarly pursuits at the expense of developing relationships, hobbies, and pastimes that provide enjoyment and balance to release stresses and renew energy. Even good students can be the recipients of pressure, threats, and admonitions to achieve spiraling levels of achievement and excellence. When adolescents whose identify is too aligned with school-related pursuits develop anxiety over the need for continued performance, some may become preoccupied with suicide as a means to escape increasing pressures. Death may seen preferable to the possibility of failing and the threat of not meeting expectations.

Constant mobility. Although a reasonable amount of change and mobility can be renewing and energizing, too much mobility can provide the basis for isolation, loneliness, and alienation. Often mobility is mandated because of career opportunities, divorce, or a desire to improve environmental circumstances. Unfortunately, too much movement can result in depression and exhaustion. Some groups, such as those living in the central or rapidly changing portions of a city, immigrants, and families working for large companies (McAnarney, 1979) may not be able to exercise enough control over mobility demands. Such demands can make it extremely difficult for adolescents' families to cope and adjust.

High school completion. Graduating from high school is an important transition or "rite of passage" for most adolescents. High school graduation symbolizes the end of childhood and the beginning of independence and young adulthood. Young people are "expected" to take more initiative in the process of further developing autonomy and independence from their families of origin. Options for employment, further education, military service, marriage, and other areas must all be considered; choice points are complex and decisions can have both long- and short-term effects. Even though many adolescents register emphatic complaints about the requirements connected with progression through and graduation from secondary education and "proclaim" the joys of high school completion, most adolescents experience a great deal of stress about the future. Suddenly, they will no longer be with peers they may have seen daily for years; the post-high school environment may be completely new and lack the "structure" secondary schools provide. Adolescents already at risk for suicide may be even more vulnerable prior to and after graduation because their stress levels may further impair decision making, coping, and adjustment relative to the myriad changes and transitions they will experience.

Availability of drugs. Most fifth and sixth graders in the United States can access the use of illicit drugs. Opportunities to experiment with alcohol, marijuana, and other drugs are common, and often young people are pressured by their peers to participate and threatened with expulsion from the group if they refuse. Many vulnerable upper-elementary school children and early adolescents mistake or confuse their involvement with the drug culture as something that can enhance their feelings of well-being and autonomy. Because problem-solving ability, self-esteem, or communication skills, which may already be inadequate, are never enhanced through the use of drugs, suicide-prone adolescents usually become even higher risks as drug experimentation and dependency increase. Parents often do not recognize either the profile of the drug-abusing adolescent or that of the suicidal adolescent, and the situation may progress to the point of a crisis prior to intervention of any kind. Often schools do not have prevention, crisis management, or postvention programs and services related to either suicide prevention or drug abuse. Though communities may express concern and request diagnostic, counseling, and related services, school boards often refuse to fund necessary services and voters do not support increased taxes.

The world community. Today's young people are completely aware of the fact that no nation or component of the world community can be totally independent or safe from the actions, and the results of those actions, of another country. The economic choices, military decisions, election results, environmental problems, treaties, and other events all affect the quality of life in communities around the world. The nuclear accident in Chernobyl, for example, and the resultant radioactive fallout experienced around the world lends reinforcement to the fact that no one can be safe from a nuclear detonation no matter how far the distance. Some adolescents cite these observations as reasons for considering suicide.

Intervention Strategies

Negotiating With Administrators

There is a compelling need for prevention, crisis management, and postvention programs for the adolescent suicide problem to be put in place in elementary, middle, and high schools throughout the country. Based on the experience of these authors in the process of working with school districts all over the country, one of the biggest mistakes of counselors, educators, and coordinators of counseling/student services is to initiate programs and services in this area without first obtaining commitment and support of administrators and others in supervisory positions. Too often efforts are initiated and then cancelled because little or no negotiation with those in decision-making positions has taken place. Building principals must be supportive; otherwise all efforts are destined for failure. Developing understanding of the parameters connected with suicide prevention and intervention must start with the building principal and extend to all faculty and staff in a given building so that advance understanding of why quick action must take place is developed. During a crisis schedules must be rearranged and faculty and staff may be called upon to teach an extra class, assist with an initial assessment, and so forth. Everyone connected with a given building must have advance preparation.

In addition to the groundwork that must be done on the building level, it is also important to effect advance communication and planning at the district level. The superintendent, assistant superintendent, curriculum director, staff development director, student services coordinator, research and program evaluation specialist, and others must all commit their support to intervention efforts. When administrators have the opportunity to listen to an overview of proposed efforts and ask questions, a higher level of commitment can be established and efforts can be more easily expedited. The probability of extending proposed programming to all schools in a given district is also increased.

Faculty/Staff Inservice

Because teachers and other faculty and staff usually learn of a student's suicidal preoccupation prior to the situation being brought to the attention of the school counselor or another member of the core or crisis team (assuming such a team exists), *all* faculty and staff must be included in building or district-level inservice on the topic of adolescent suicide. Teachers, aides, secretaries, administrators, custodians, bus drivers, food service personnel, librarians, school social workers, and others all come in contact with adolescents at risk for suicide. It is imperative that all such adults be educated about both adolescent suicide and building and district policies and programs for prevention, crisis management, and postvention. When a young person reaches out to a trusted adult, that adult must have a clear understanding and a considerable amount of self-confidence so he or she knows exactly what to say and do as well as what not to say and do.

Many schools and school districts have actually precipitated suicide attempts by not providing for faculty/staff inservice on the topic prior to introducing discussion among student groups. When middle and high school students participate in educational programs on the topic of adolescent suicide, they begin to realize that they, as well as some of their friends, are at risk, and they approach admired adults for assistance. Adults in the school who have no knowledge of what to do and who have not had the opportunity to have their questions answered and their apprehension lowered may be threatened by what a student is sharing and fail to make appropriate comments and decisions. Highly stressed, depressed suicidal adolescents do not have the perspective to realize that such responses are connected with discomfort on the part of the adult and have little to do with what could be interpreted as disapproval and lack of acceptance. Awkward and minimal responses to suicidal self-disclosure on the part of a trusted adult can be interpreted as the loss of the last link to society and provide additional reinforcement for finalizing a suicide plan.

IT IS UNETHICAL NOT TO PREPARE SCHOOL FACULTY AND STAFF IN ADVANCE OF THE PRESENTATION OF INFORMATION ON SUICIDE TO THE STUDENTS IN A SCHOOL. TO DO SO COULD ALSO BECOME THE BASIS FOR LEGAL ACTION BY PARENTS AND FAMILY MEMBERS. The content for necessary inservice will be presented later in this chapter.

Preparation of Crisis Teams

Many schools have "crisis" or "core" teams composed of faculty, staff, and parents connected with a particular building. These teams often exist in conjunction with a program for the prevention and intervention efforts necessary to cope with the drug problem among the young people in today's schools. Such teams usually consist of some combination of teachers, counselors, parents, social workers, school psychologists, school nurses, and school administrators. Usually these teams have been educated about traits that place adolescents at risk for substance use and abuse and have had supervision and instruction on the use of appropriate communication, diagnostic, and intervention skills necessary to begin the long-term process of recovery from alcoholism and other addictions. With education beyond what is provided during the faculty/staff inservice discussed previously as well as additional supervision and evaluation of clinical skills, a "core" or "crisis" team can be taught how to facilitate prevention efforts in a school as well as how to respond to a student already experiencing a suicidal crisis or in need of postvention efforts. In addition, such a team can be expected to write a policy statement that covers all parameters connected with prevention, crisis management, and postvention efforts. Such a policy could be adopted in other schools; in reality, except for specifics connected with a given building, the same policy statement should be adopted and followed throughout a school district. It is important to realize that everyone who is called upon to assist a suicidal adolescent must know what to do. Confusion or lack of certainty about a chain of command or procedures for notifying parents can result in delays and interfere with efforts to save a young person's life!

Individual and Group Counseling Options

Prior to providing students with any information about suicide and suicide prevention efforts in a school, arrangements must be made for the individual and group counseling services that will be needed by those who seek assistance for themselves or their friends. Unless such counseling options are available, any effort at prevention, crisis management, or postvention will be doomed to failure. This may present a problem to school personnel, particularly on the secondary level, unless there is a commitment on the part of administrators to free counselors from scheduling, hall monitoring, and other duties unrelated to the emerging role of the counselor of the 1980s and 1990s. Working with suicidal adolescents requires a long-term commitment on the part of those interested in intervening. No counselor, psychologist, or social worker can undo the experiences and self-perceptions of a lifetime without providing consistent, intensive opportunities for counseling.

If the school district cannot make a commitment to providing counseling, then arrangements for referral to community agencies and private practitioners must be made. It is important to provide adolescents and their families with a variety of referral possibilities along with information on fee schedules. There may be some question about whether the school district will be liable for the cost of such counseling if the referral is made by the school. (This issue should be explored by whatever legal counsel is retained by the district.) The dilemma, of course, is that unless counseling takes place when a suicidal adolescent has been identified, the probability is high that an attempt or a completion will take place. If the school is aware of a teenager's suicidal preoccupation and does not act in the best interests of such a teenager, families may later bring suit against the district. (This issue will be further discussed later in this chapter.)

Parent Education

Parents of students in a school in which a suicide prevention program is to be initiated should be involved in the school's efforts to educate, identify, and assist young people in this respect. Parents have a right to understand why the school is taking such steps and what the components of a schoolwide effort will be like. Evening or late afternoon parent education efforts can be constructive and engender additional support for a school or school district. Parents have the same information needs as faculty and staff with respect to the topic of adolescent suicide. They will be more likely to refer themselves and their children to the school for assistance if they know of the school's interest in adolescent suicide prevention, have had an opportunity to ask questions about their adolescent sons' and daughters' behavior, and have been reassured about the quality and safety of the school's efforts.

Classroom Presentations

Debate about the safety of adolescent suicide prevention programs containing an educational component that is presented to adolescents continues. This debate is similar to the one that emerged 10 or 15 years ago when schools initiated staff development and classroom presentations on the topic of physical and sexual abuse. There are a number of advocates of education and discussion efforts that are focused on students in conjunction with a schoolwide suicide prevention effort (Capuzzi, 1986; Capuzzi & Golden, 1988; Curran, 1987; Ross, 1980; Sudak, Ford, & Rushforth, 1984). Providing adolescents with an appropriate forum in which they can receive accurate information, ask questions, and learn about how to obtain help for themselves and their friends does not precipitate suicidal preoccupation or attempts (Capuzzi, 1988). Because newspaper and television reports of individual and cluster suicides do not usually include adequate education on the topic, and because many films have unrealistically presented or romanticized the act of suicide, it is important for schools to address the problem in a way that provides information and encourages young people to seek help prior to reaching the point of despair. A carefully planned and well-presented classroom presentation by a member of the school's crisis team (or another presenter who has expertise on the topic) is essential. Such a presentation should include both information on causes, myths, and symptoms, as well as information about how to obtain help through the school. *Under no circumstances should media be used in which adolescents are shown a suicide plan.* In addition, on the elementary level, school faculty should not present programs on the topic of suicide prevention; their efforts are better focused on developmental counseling and classroom presentations directed at helping children overcome traits (such as low self-esteem or poor communication skills) that may put them at risk for suicidal behavior at a later time. Although these efforts should be continued through secondary education, middle and high school students are better served through presentations that address adolescent suicide directly. (Middle and high school students almost always have direct or indirect experience with suicide and appreciate the opportunity to obtain information and ask questions.)

Staff Development Efforts

As discussed earlier, it is unethical to initiate a suicide prevention effort in any context unless the adults who come in contact with adolescents have been prepared in advance. Generally, it takes a minimum of 2 full days to prepare teachers and other staff to play their roles in a total school program for suicide prevention. Additional time is required for preparation of core or crisis teams and for development of a written plan of action for suicide prevention, crisis management, and postvention. Some schools prefer that everyone obtain 2 full days of staff development on the topic; others provide 1 day for the entire faculty and staff and the second day only for members of the core or crisis teams.

The purpose of such inservice efforts is to sensitize each adult to the problem of adolescent suicide and the school's role in intervention so that each adult can identify those at risk and provide support in the process of referring students for help to the school counselor and other members of core or crisis teams. Under no circumstances are faculty and staff to attempt to provide the counseling or assessment services that can only be offered by someone with appropriate expertise. All adults in a setting in which preventive education is presented to adolescents must, at a minimum, understand the myths, the profile of the potential attempter, and the guidelines for making referrals.

The following information will provide the reader with ideas about the content of inservice education for faculty and staff. Because of length limitations for this chapter, it is not possible to provide the content for a comprehensive "curriculum." Moreover, the material should not be used by someone who is not a qualified school or mental health professional because of the questions participants in such inservice groups ask about suicidal dynamics, diagnosis, and the counseling/therapy process.

Understanding the Myths

It is important to disqualify myths and misconceptions about adolescent suicide at the beginning of any initiative to provide prevention, crisis management, and postvention services. Some of the most commonly cited misconceptions include the following (Capuzzi, 1988).

Adolescents who talk about suicide never attempt suicide. This is probably one of the most widely believed myths. All suicidal adolescents make attempts (either verbal or nonverbal) to let a friend, parent, or teacher know that life seems to be too difficult to bear. Because a suicide attempt is a cry for help to identify options, other than death, to decrease the pain of living, always take verbal threats seriously. Never assume such threats are only for the purpose of attracting attention or manipulating others. It is better to respond and enlist the aid of a professional than it is to risk the loss of a life.

Suicide happens with no warning. Suicidal adolescents leave numerous hints and warnings about their suicidal ideations and intentions. Clues can be verbal or in the form of suicidal gestures such as taking a few sleeping pills, becoming accident-prone, reading stories focused on death and violence, and so forth. Often the social support network of the suicidal adolescent is small. As stress escalates and options, other than suicide, seem few, suicidal adolescents may withdraw from an already small circle of friends, making it more difficult for others to notice warning signs.

Adolescents from affluent families attempt or complete suicide more often than adolescents from poor families. This, too, is a myth. Suicide is evenly divided among socioeconomic groups.

Once an adolescent is suicidal, he or she is suicidal forever. Most adolescents are suicidal for a limited period of time. In the experience of the authors, the 24–72 hour period around the peak of the "crisis" is the most dangerous. If counselors and other mental health professionals can monitor such a crisis period and get the adolescent into long-term counseling/therapy, there is a strong possibility the adolescent will never have another suicidal crisis. The more effort that is made to help an adolescent identify stressors and develop problem-solving skills during this postsuicidal crisis period and the more time that passes, the better the prognosis.

If an adolescent attempts suicide and survives, he or she will never make an additional attempt. There is a difference between an adolescent who experiences a suicidal crisis but does not attempt suicide, as in the example above, and the adolescent who actually makes an attempt. An adolescent who carries through with an attempt has identified a plan, has had access to the means, and has maintained a high enough energy level to follow through. He or she may believe that a second or third attempt may be possible. If counseling/therapy has not taken place or has not been successful during the period following an attempt, additional attempts may be made. Most likely, each follow-up attempt will become more lethal.

Adolescents who attempt or complete suicide always leave notes. Only a small percentage of suicidal adolescents leave notes. This is a common myth and one of the reasons why many deaths are classified and reported as accidents by friends, family members, physicians, and investigating officers when suicide has actually taken place.

Most adolescent suicides happen late at night or during the predawn hours. This myth is not true for the simple reason that most suicidal adolescents actually want help. Mid to late morning and mid to late afternoon are the time periods when most attempts are made because a family member or friend is more likely to be around to intervene than would be the case late at night or very early in the morning.

Never use the word suicide when talking to adolescents because using the word gives some adolescents the idea. This is simply not true; you cannot put the idea of suicide into the mind of an adolescent who is not suicidal. If an adolescent is suicidal and you use the word, it can help the adolescent verbalize feelings of despair and assist with establishing rapport and trust. If a suicidal adolescent thinks you know he or she is suicidal and realizes you are afraid to approach the subject, it can bring the adolescent closer to the point of making an attempt by contributing to feelings of despair and helplessness.

Every adolescent who attempts suicide is depressed. Depression is a common component of the profile of a suicidal adolescent but it is not always a component. Many adolescents simply want to escape their present set of circumstances and do not have the problem-solving skills to cope more effectively, lower stress, and work toward a more promising future.

Suicide is hereditary. Suicide tends to run in families, just as physical and sexual abuse does, and has led to the development of this myth. Suicide is not genetically inherited. Members of families do, however, share the same emotional climate because parents model coping and stress-management skills as well as a level of high or low self-esteem. The suicide of one family member tends to increase the risk among other family members that suicide will be viewed as an appropriate way to solve a problem or set of problems.

In conjunction with this myth, it should be noted that endogenous depression can be inherited. Because of the connection between depression and suicide, many have mistakenly come to the belief that suicide can be genetically inherited.

Recognizing the Profile

A number of experts (Capuzzi & Golden, 1988; Curran, 1987; Davis, 1983; Hafen & Frandsen, 1986; Hussain & Vandiver, 1984; Johnson & Maile, 1987) believe that about 90% of the adolescents who complete suicide (and lethal first attempts can result in completions) give cues to those around them in advance. Whether these cues or hints are limited or numerous will depend on the adolescent because each adolescent has a unique familial and social history. It is important for adults (and young people as well) to recognize the signs and symptoms to facilitate intervention. A comment such as "I talked with her a few days ago and she was fine—I am so shocked to learn of her death" may mean that no one was aware of the warning signs. One of the essential components of any staff development effort is teaching the profile of the suicidal or potentially suicidal adolescent so that referral and intervention can take place. Behavioral, verbal, and cognitive cues, as well as personality traits, are the four areas described below.

Behaviors

Lack of concern about personal welfare. Some adolescents who are suicidal may not be able to talk about their problems or give verbal hints that they are at risk for attempting suicide. Sometimes such adolescents become unconcerned with their personal safety in the hopes that someone will take notice. Experimenting with medication, accepting "dares" from friends, reckless driving, carving initials into the skin of forearms and so forth may all be ways of "gesturing" or letting others know, "I am in pain and don't know how to continue through life if nothing changes."

Changes in social patterns. Relatively unusual or sudden changes in an adolescent's social behavior can provide strong cues that such a young person is feeling desperate. A cooperative teenager may suddenly start breaking the "house rules" that parents have never had to worry about enforcing. An involved adolescent may begin to withdraw from activities at school or end long-term friendships with school and community peers. A stable, easy-going teenager may start arguing with teachers, employers, or other significant adults with whom prior conflict was never experienced. Such pattern changes should be noted and talked about with an adolescent who does not seem to be behaving as he or she usually has in the past.

A decline in school achievement. Often adolescents who are becoming increasingly depressed and preoccupied with suicidal thoughts are unable to devote the time required to complete homework assignments and maintain grades. If such an adolescent has a history of interest in the school experience and has maintained a certain grade point average, loss of interest in academic pursuits can be a strong indication that something is wrong. The key to assessing such a situation is the length of time the decline lasts.

Concentration and clear thinking difficulties. Suicidal adolescents usually experience marked changes in thinking and logic. As stress and discomfort escalate, logical problem solving and option generation become more difficult. It becomes easier and easier to stay focused on suicide as the only solution as reasoning and thinking become more confused and convoluted. "It may become more and more obvious that the adolescent's attention span is shorter and that verbal comments bear little relationship to the topic of a conversation" (Capuzzi, 1988, p.6).

Altered patterns of eating and sleeping. Sudden increases or decreases in appetite and weight, and difficulty with sleeping or wanting to sleep all the time or all day, can indicate increasing preoccupation with suicidal thoughts. These altered patterns can offer strong evidence that something is wrong and that assistance is required.

Attempts to put personal affairs in order or to make amends. Often, once a suicide plan and decision have been reached, adolescents will make "last minute" efforts to put their personal affairs in order. These efforts may take a variety of directions: attempts to make amends in relation to a troubled relationship, final touches on a project, reinstatement of an old or neglected friendship, or the giving away of prized possessions (skis, jewelry, compact discs, collections, etc.).

Use or abuse of alcohol or drugs. Sometimes troubled adolescents use or abuse alcohol or other drugs to lessen their feelings of despair or discontent. Initially, they may feel that the "drug" enhances their ability to cope and to increase feelings of self-esteem. Unfortunately, the abuse of drugs decreases the ability to communicate accurately and solve problems rationally. Thinking patterns become skewed, impulse control lessens, and option identification decreases. Rapid onset of involvement with illicit or over-the-counter drugs is indicative of difficulty with relationships, problem solving, and ability to share feelings and communicate them to others.

Unusual interest in how others are feeling. Suicidal adolescents often express considerable interest in how others are feeling. Because they are in pain, but may be unable to express their feelings and ask for help, they may reach out to peers (or adults) who seem to need help with the stresses of daily living. Such responsiveness may become a full-time pastime and serve to lessen preoccupation with self and to serve as a vehicle for communicating, "I wish you would ask me about my pain" or "Can't you see that I need help too?"

Preoccupation with death and violence themes. Reading books or poetry in which death, violence, or suicide is the predominant theme can become the major interest of an adolescent who is becoming increasingly preoccupied with the possibility of suicide. Such adolescents may be "undecided" about the possibility of choosing death over life and may be working through aspects of such a decision with this reading. Other examples of such preoccupation can include listening to music that is violent, writing short stories focused on death, dying, and loss, drawing or sketching that emphasizes destruction, or watching movies that emphasize destruction to self and others.

Sudden improvement after a period of depression. Suicidal adolescents often fool parents, teachers, and friends by seeming to be dramatically improved shortly after a period of prolonged depression. This improvement can sometimes take place overnight or during a 24-hour period and encourages friends and family who interpret this change as a positive sign. It is not unusual for a change of this type to be the result of a suicide decision and the formulation of a concrete suicide plan on the part of the adolescent at risk. It may mean that the suicide attempt (and the potential of completion) is imminent and that the danger and crisis are peaking. The important point for family and friends to remember is that it is not really logical for a depression to lessen that rapidly. It takes time, effort, and, at times, medical assistance, to improve coping skills and lessen feelings of depression just as it took time (months or years) to develop nonadaptive responses to people and circumstances and feelings of hopelessness.

Sudden or increased promiscuity. It is not unusual for an adolescent to experiment with sex during periods of suicidal preoccupation in an attempt to refocus attention or lessen feelings of isolation. Unfortunately, doing so sometimes complicates circumstances because of an unplanned pregnancy or an escalation of feelings of guilt.

Verbal Cues

As Schneidman, Farbverow, and Litman (1976) noted, verbal statements can provide cues to self-destructive intentions. Such statements should be assessed and considered in relation to behavioral signs, changes in thinking patterns, motivations, personality traits, and so forth. There is no "universal" language or "style" for communicating suicidal intention. Some adolescents will openly and directly say something like "I am going to commit suicide," or "I am thinking of taking my life." Others will be far less direct and make statements such as: "I'm going home," "I wonder what death is like," "I'm tired," "She'll be sorry for how she has treated me," or "Someday I'll show everyone just how serious I am about some of the things I've said."

The important thing for counselors, parents, teachers, and friends to remember is that when someone says something that could be interpreted in a number of ways, it is always best to ask for clarification. It is not a good idea to make assumptions about what a statement means or to minimize the importance of what is being communicated. Suicidal adolescents often have a long-term history of difficulty with communicating feelings and asking for support. Indirect statements may be made in the hope that someone will respond with support and interest and provide or facilitate a referral for professional assistance.

Thinking Patterns and Motivations

In addition to the areas previously described, thinking patterns and motivations of suicidal adolescents can also be assessed and evaluated. For such an assessment to occur, it is necessary to encourage self-disclosure to learn about changes in an adolescent's cognitive set and distortions of logic and problem-solving ability. As Velkoff and Huberty (1988) noted, the motivations of suicidal adolescents can be understood more readily when suicide is viewed as fulfilling one of three primary functions: (1) an avoidance function that protects the individual from the pain perceived to be associated with a relationship or set of circumstances; (2) a control function that enables an adolescent to believe he or she has gained control of someone or something thought to be out of control, hopeless, or disastrous; and (3) a communication function that lets others know that something is wrong or that too much pain or too many injuries have been accumulated.

Often suicidal adolescents distort their thinking patterns in conjunction with the three functions of avoidance, control, and communication so that suicide becomes, and remains focused on, as the best or only problem-solving option. Such distortions can take a number of directions. All-or-nothing thinking, for example, can enable an adolescent to view a situation in such a polarized way that the only two options seem to be continuing to be miserable and depressed or carrying out a suicide plan; no problem-solving options to cope with or overcome problems may seem possible (Capuzzi, 1988). Identification of a single event that is then applied to all events is another cognitive distortion, that of overgeneralization. Being left out of a party or trip to the mountains with friends may be used as "evidence" for being someone no one likes, a "loser," or someone who will always be forgotten or left out. "I can't seem to learn the material for this class very easily" becomes "I'm never going to make it through school," or "I'll probably have the same difficulties when I start working full time." Adolescents who are experiencing stress and pain and who are becoming preoccupied with suicidal thoughts often experience increasing cognitive distortions. Such distortions result in self-talk that becomes increasingly negative and supportive of one of the following motivations for carrying through with a suicide plan:

- Wanting to escape from a situation that seems (or is) intolerable (e.g., sexual abuse, conflict with peers or teachers, pregnancy, etc.);
- Wanting to join someone who has died;
- Wanting to attract the attention of family or friends;
- Wanting to manipulate someone;
- Wanting to avoid punishment;
- Wanting to be punished;
- Wanting to control when or how death will occur (an adolescent with a chronic or terminal illness may be motivated in this way);
- Wanting to end a conflict that seems unresolvable;
- Wanting to punish the survivors; and
- Wanting revenge.

Personality Traits

As Capuzzi (1988) noted, it would be ideal if the research on suicidal adolescents provided practitioners with such a succinct profile of personality traits that teenagers at risk for suicide could be identified far in advance of any suicidal risk. Adolescents who fit the profile could then be assisted through individual and group counseling and other means. Although no consensus has yet been reached on the "usual," "typical," or "average" constellation of personality traits of the suicidal adolescent, researchers have agreed on a number of characteristics that seem to be common to many suicidal adolescents.

Low self-esteem. A number of studies (Cull & Gill, 1982; Faigel, 1966; Stein & Davis, 1982; Stillion, McDowell, & Shamblin, 1984) have connected low self-esteem with suicide probability. The counseling experience of the authors, as well as the experience of other practitioners, seems to substantiate the relationship between low self-esteem and suicide probability. Almost all such clients have issues focused on feelings of low self-worth, and almost all such adolescents have experienced these self-doubts for an extended period of time.

Hopelessness/helplessness. Most suicidal adolescents report feeling hopeless and helpless in relation to their circumstances as well as their ability to cope with these circumstances. The research support (Cull & Gill, 1982; Kovacs, Beck, & Weissman, 1975; Jacobs, 1971; Peck, 1983) for verification of what clinicians report is growing. Most practitioners can expect to address this issue with suicidal clients and to identify a long-term history of feeling hopeless and helpless on the part of most clients.

Isolation. Many, if not most, suicidal adolescents tend to develop a small network of social support. They may find it uncomfortable to make new friends and rely on a small number of friends for support and companionship. This may be the reason why so often those around a suicide victim state they did not notice anything unusual. The suicidal adolescent may not be in the habit of getting close enough to others so that changes in behavior or outlook can be noted. A number of authorities (Hafen, 1972; Kiev, 1977; Peck, 1983; Sommes, 1984; Stein & Davis, 1982) seem to support this observation.

High stress. High stress, coupled with poor stress management skills, seems to be characteristic of the suicidal adolescent. A number of studies have addressed this trait in terms of low frustration tolerance (Cantor, 1976; Kiev, 1977).

Acting out. Behaviors such as truancy, running away, refusal to cooperate at home or at school, use or abuse of alcohol or other drugs, and experimentation with sex are frequently part of the pattern in the life of a suicidal adolescent. Such behaviors may be manifestations of depression. Often, adults remain so focused on the troublesome behavior connected with an adolescent's need to act out that underlying depressive episodes may be overlooked.

Need to achieve. Sometimes suicidal adolescents exhibit a pattern of high achievement. This achievement may be focused on getting high grades, being the "class clown," accepting the most "dares," wearing the best clothes, or any one of numerous other possibilities. In the counseling experience of the writers, this emphasis on achievement often is a compensation for feelings of low self-esteem. Readers should be cautioned, however, about jumping to the conclusion that every adolescent who achieves at a high level is suicidal. This trait, along with all the other traits and characteristics connected with the profile of the suicidal adolescent, must be assessed in the context of other observations.

Poor communication skills. Suicidal adolescents often have a history of difficulty in expressing thoughts and feelings. Such adolescents may have trouble with identifying and labeling what they are feeling; self-expression seems awkward if not stressful. It is not unusual to discover that adolescents who have become preoccupied with suicidal thoughts have experienced a series of losses or disappointments that they have never been able to discuss and, understandably, integrate or resolve.

Other-directedness. Most suicidal adolescents are "other" rather than "inner" directed. They are what others have told them they are instead of what they want to be; they value what others have said they "should" value instead of what they deem to be of personal value and worth. This trait may also be linked to low self-esteem and may lead to feelings of helplessness or inability to control interactions or circumstances around them.

Guilt. Usually connected with feelings of low self-esteem and a need to be other-directed, the guilt many suicidal adolescents experience is bothersome and sometimes linked to a "wanting to be punished" motivation for suicide. "Nothing I do seems to be good enough," or "I feel so bad because I disappointed them," or "I should not have made that decision and should have known better" are statements common to the guilt-ridden suicidal adolescent.

Depression. Depression is a major element in the total profile of the suicidal adolescent. Hafen and Frandsen (1986) pointed out that sometimes there are differences between depression in an adult and depression in an adolescent. Adults are often despondent, tearful, sad, or incapable of functioning as usual. Although adolescents sometimes exhibit these characteristics, they may also respond with anger, rebelliousness, truancy, running away, or using and abusing drugs. Those adults and peers who associate depression only with feelings of sadness and despondency may not recognize depression in adolescents who mask it with behavior that creates discomfort in a family and school environment.

As Capuzzi (1988) noted:

> Given the complexity of being an adolescent in the late 1980s, coupled with the normal ups and downs of the developmental stage of adolescence, it is normal for every adolescent to experience short periods of depression. But when depressive periods become more and more frequent, longer and longer, and of such intensity that the adolescent has difficulty functioning at school and at home, they could be a strong warning sign of suicide potential, especially if other aspects of behavior, verbalization, motivations and cognitive distortions have been observed. (p.10)

It is extremely important for counselors and other professionals who may be working with suicidal adolescents to complete additional coursework or training to learn about the different types of depression. Although familiarity with resources and guidelines such as those provided by McWhirter and Kigin (1988) and the *Diagnostic and Statistical Manual of Mental Disorders—Revised* (American Psychiatric Association, 1987) are readily available to mental health practitioners, case supervision and consultation may be needed to accurately determine the nature of a depressive episode. Frequently, well-meaning practitioners fail to discriminate between depression created by a constellation of factors (negative self-talk, poor problem-solving skills, high stress, etc.) and depression that is endogenous and a result of the body chemistry inherited at birth. Treatment or counseling plans are different based on the kind of depression experienced. Counselors, therapists, and core or crisis team members need to collaborate with nurse-practitioners and psychiatrists when medical assessment and subsequent medication are appropriate for endogenous depression.

Poor problem-solving skills. Most parents notice differences in the problem-solving ability of their children. Some children are more resourceful than others in identifying problem resolution options. Suicidal adolescents seem, in the experience of the writers, to have less ability to develop solutions to troublesome situations or uncomfortable relationships. This may be a reason why suicidal preoccupation can progress from a cognitive focus to an applied plan, with little dissonance created by the formulation and consideration of other problem-solving options and decisions.

Planning Prevention, Crisis Management, and Postvention Efforts

Staff development efforts should always include information about the prevention, crisis management, and postvention components that must be part of all "systems" efforts to intervene in the adolescent suicide problem. In school settings it is important for all faculty and staff to understand the importance of all three components, even though members of the core or crisis teams will be the individuals in the school who will carry out most, if not all, of the crisis management and postvention efforts.

Prevention

Most suicidal adolescents have developed their "at-risk" profiles over time, beginning during early childhood. In families with more than one child, it is often easy for parents to identify differences in self-esteem, communication skills, stress management, and problem solving. By the time a child is in elementary school, there may be visible indicators or traits that, if no intervention takes place, will result in the child's involvement in one or several at-risk behaviors. In the opinion of the authors, such a child, by the time the middle school or junior high transition occurs, will be vulnerable to becoming pregnant, contracting AIDS, abusing drugs, developing an eating disorder, dropping out, or attempting or completing suicide.

It is extremely important for counselors and other core team members in elementary schools to provide the mental health education and developmental counseling so necessary for prevention purposes. Although the authors do not recommend calling such efforts "suicide prevention" at the elementary level, it is important for school personnel to provide mental health education through classroom guidance sessions designed to help children overcome traits that put them at risk later in life. Programs focused on self-esteem enhancement, stress management, problem solving, understanding and communicating feelings, and so forth are of paramount importance. Such programming should be carefully and sequentially planned, and classroom teachers should be assisted with implementation and reinforcement efforts. In addition, small group counseling should be available for students who seem to need more assistance than that which can be provided in a classroom learning environment. Ongoing one-to-one counseling should also be made available for those in need of individual attention.

By the time young people are in middle or high school, they may have had contact with a peer who attempted or completed the act of suicide. In addition, most students of middle and high school age have been exposed to films as well as newspaper and television journalism highlighting the adolescent suicide problem. Because of the impact of one or a combination of the above factors, the authors believe that suicide prevention efforts at these levels should be labeled as such because students are usually candid with their questions and observations related to adolescent suicide. As noted earlier in conjunction with staff development efforts, it is critical that educational programs before classroom groups be carefully planned and rehearsed as well as delayed until such time as crisis, postvention, referral, and counseling services are in place. It is also important to continue with more generalized mental health education efforts as well as small group and individual counseling options.

Crisis Management

If an adolescent has been identified as potentially suicidal, every possible step should be taken to involve the adolescent in ongoing counseling so that preventive steps can be taken quickly and proactively. A number of cognitive-behavioral models have proven effective with depressed, suicidal adolescents. Albert Ellis (1979), John Krumboltz and Carl Thoresen (1976), and Arnold Lazarus (1976) have presented frameworks for counselors to use with such adolescents. Numerous films, filmstrips, and videos are available for classroom guidance presentations (Kidsrights, 1989). In addition, the American Association of Suicidology's journal, *The Journal of Suicide and Life Threatening Behavior*, is an excellent resource for professionals.

There are times, however, that adolescents at risk for suicide are not identified until a crisis state has been reached. In such circumstances, it is important for all concerned to initiate action to assess lethality and determine appropriate follow-up. Because many professionals who are not counselors lack experience with adolescents who are in the midst of a personal crisis, the following guidelines may prove helpful.

1. Remember the meaning of the term "crisis management." When thinking of crisis management, it is important to understand the meaning of the word "crisis" as well as the word "management." The word "crisis" means that the situation is not usual, normal, or average; circumstances are such that a suicidal adolescent is highly stressed and in considerable emotional discomfort. Adolescents in crisis usually feel vulnerable, hopeless, angry, low in self- esteem, and at a loss for how to cope. The word "management" means that the professional involved must be prepared to apply skills that are different that those required for preventive or postvention counseling. An adolescent in crisis must be assessed, directed, monitored, and guided for the purpose of preventing an act of self-destruction. Because adolescents who are experiencing a suicidal crisis may be volatile and impulsive, the need for decisive, rapid decision making on the part of the intervener is extremely important.

2. Be calm and supportive. A calm, supportive manner on the part of the intervener conveys respect for the perceptions and internal pain of an adolescent preoccupied with suicidal thoughts. Remember that such an adolescent usually feels hopeless and highly stressed. The demeanor and attitude of the helping person is pivotal in the process of offering assistance.

3. Be nonjudgmental. Statements such as "You can't be thinking of suicide, it is against the teachings of your church," or "I had a similar problem when I was your age and I didn't consider suicide" are totally inappropriate during a crisis situation. An adolescent's perception of a situation is, at least temporarily, real and that reality must be respected. The same caution can be applied to the necessity of respecting a suicidal adolescent's expression of feelings whether these feelings are those of depression, frustration, fear, or helplessness. Judgmental, unaccepting responses and comments serve only to further damage an already impaired sense of self-esteem and decrease willingness to communicate. Adolescents could sink further into depression or increase their resolve to carry through with a suicide plan if others are critical and unwilling to acknowledge what seem, to the adolescent, to be unsurmountable obstacles.

4. *Encourage self-disclosure.* The very act of talking about painful emotions and difficult circumstances is the first step in what can become a long-term healing process. A professional helper may be the first person with whom such a suicidal adolescent has shared with and trusted in months or even years, and it may be difficult to do simply because of lack of experience with communicating thoughts and feelings. It is important to support and encourage self-disclosure so that an assessment of lethality can be made early in the intervention process.

5. *Acknowledge the reality of suicide as a choice, but do not "normalize" suicide as a choice.* It is important for practitioners to let adolescents know that they are not alone and isolated with respect to suicidal preoccupation. It is also important to communicate the idea that suicide is a choice, a problem-solving option, and that there are other choices and options. This may be difficult to do in a way that does not make such an adolescent feel "judged" or "put down." "It is not unusual for adolescents to be so upset with relationships or circumstances that thoughts of suicide occur more and more frequently; this does not mean that you are weird or a freak. I am really glad you have chosen to talk to me about how you're feeling and what you are thinking. You have made a good choice because, now, you can begin exploring other ways to solve the problems you described" is an example of what could be said to an adolescent in crisis.

6. *Listen actively and reinforce positively.* It is important, during the initial stages of the crisis management process, to let the adolescent at risk for suicide know you are listening carefully and really understanding how difficult life has been. Not only will such careful listening and communicating, on the part of the professional, make it easier for the adolescent to share, but it will also provide the basis for a growing sense of self-respect. Being listened to, heard, and respected is a powerful and empowering experience for anyone who is feeling at a loss for how to cope.

7. *Do not attempt in-depth counseling.* Although it is very important for a suicidal adolescent to begin to overcome feelings of despair and to develop a sense of control as soon as possible, the emotional turmoil and stress experienced during a crisis usually makes in-depth counseling impossible. Developing a plan to begin lessening the sense of crisis an adolescent may be experiencing is extremely important, however, and should be accomplished as soon as possible. Crisis management necessitates the development of a plan to lessen the crisis; this plan should be shared with the adolescent so that it is clear that circumstances will improve. Counseling/therapy cannot really take place during the height of a suicidal crisis.

8. Contact another professional. It is a good idea to enlist the assistance of another professional, trained in crisis management, when an adolescent thought to be at risk for suicide is brought to your attention. School and mental health counselors should ask a colleague to come into the office and assist with assessment. It is always a good idea to have the support of a colleague who understands the dynamics of a suicidal crisis; in addition, the observations made by two professionals are likely to be more comprehensive. Because suicidal adolescents may present a situation that, if misjudged or mismanaged, could result in a subsequent attempt or completion, it is in the best interests of both the professional and the client for professionals to work collaboratively whenever possible. It should also be noted that liability questions are less likely to become issues and professional judgment is less likely to be questioned if assessment of the severity of a suicidal crisis and associated recommendations for crisis management have been made on a collaborative basis.

9. Ask questions to assess lethality. A number of dimensions must be explored to assess lethality. This assessment can be accomplished through an interview format (a crisis situation is not conducive to the administration of a written appraisal instrument). The following questions help determine the degree of risk in a suicidal crisis; all of them do not need to be asked if the interview results in the spontaneous disclosure of the information.

"*What has happened to make life so difficult?*" The more an adolescent describes the circumstances that have contributed to feelings of despair and hopelessness, the better the opportunity for effective crisis management. The process of describing stress-producing interpersonal situations and circumstances may begin to lower feelings of stress and reduce risk. It is not unusual for an adolescent in the midst of a suicidal crisis to describe a multifaceted set of problems with family, peers, school, and drugs. The more problems an adolescent describes as stress-producing and the more complicated the scenario, the higher the lethality or risk.

"*Are you thinking of suicide?*" Adolescents who have been preoccupied with suicidal thoughts may experience a sense of relief to know there is someone who is able to discuss suicide in a straightforward manner. Using the word "suicide" will convey that the helping professional is listening and is willing to be involved; using the word "suicide" will not put the idea of suicide in the mind of a nonsuicidal adolescent.

"*How long have you been thinking about suicide?*" Adolescents who have been preoccupied with suicide for a period of several weeks are more at risk than those who have only fleeting thoughts. One way to explore several components of this question is to remember the acronym "FID." When asking about suicidal thoughts, ask about *frequency*, or how often they occur, *intensity*, or how dysfunctional the preoccupation is making the adolescent ("Can you go on with your daily routine as usual?"), and *duration*, or how long the periods of preoccupation last. Obviously, an adolescent who reports frequent periods of preoccupation so intense that it is difficult or impossible to go to school, to work, or to see friends, and for increasingly longer periods of time so that periods of preoccupation and dysfunction are merging, is more at risk than an adolescent who describes a different set of circumstances.

"Do you have a suicide plan?" When an adolescent is able to specify the method, the time, the place, and who will or will not be nearby, the risk is higher. (If the use of a gun, knife, medication, or other means is described, ask if that item is in a pocket or purse and request that the item be left with you. Never, however, enter into a struggle with an adolescent to remove a firearm. Call the police or local suicide or crisis center.) Most adolescents will cooperate with you by telling you about the plan and allowing you to separate them from the means. Remember, most suicidal adolescents are other-directed; such a trait should be taken advantage of during a crisis management situation. Later, when the crisis has subsided and counseling is initiated, the adolescent's internal locus of control can be strengthened.

"Do you know someone who has committed suicide?" If the answer is "yes," the adolescent may be at higher risk especially if this incident occurred within the family or a close network of friends. Such an adolescent may have come to believe that suicide is a legitimate problem-solving option.

"How much do you want to live?" An adolescent who can provide only a few reasons for wishing to continue with life is at higher risk than an adolescent who can enumerate a number of reasons for continuing to live.

"How much do you want to die?" The response to this question provides the opposite view of the one above. An adolescent who gives a variety of reasons for wishing to die is more at risk than an adolescent who cannot provide justification for ending life. It may be unnecessary to ask this question if the previous question provided adequate data.

"What do you think death is like?" This question can be an excellent tool of assessment. Adolescents who do not seem to realize that death is permanent, that there is not reversal possible, and that they cannot physically return are at higher risk for an actual attempt. Also, adolescents who have the idea that death will be "romantic," "nurturing," or "the solution to current problems" are at high risk.

"Have you attempted suicide in the past?" If the answer to this question is "yes," then the adolescent is more at risk. Another attempt may occur that could be successfull because a previous attempter has

the memory of prior efforts and the fact that he or she conceptualized and carried through with a suicide plan. An additional attempt may correct deficits in the original plan and result in death.

"How long ago was this previous attempt?" is a question that should be asked of any adolescent who answers "yes" to the previous question. The more recent the previous attempt, the more at risk the adolescent is and the more critical is the crisis management process.

"Have you been feeling depressed?" Because a high percentage of adolescents who attempt or complete suicide are depressed, this is an important question. Using the acronym FID to remember to ask about frequency, intensity, and duration is also helpful in the context of exploring an adolescent's response to this question. As previously discussed, a determination needs to be made relative to the existence of clinical depression if such a condition is suspected. Adolescents who report frequent, intense, and lengthy periods of depression resulting in dysfunctional episodes that are becoming more frequent or are continuously experienced are at high risk.

"Is there anyone to stop you?" This is an extremely important question. If an adolescent has a difficult time identifying a friend, family member, or significant adult who is worth living for, the probability of a suicide attempt is high. Whoever the adolescent can identify should be specifically named; addresses, phone numbers, and the relationship to the adolescent should also be obtained. (If the adolescent cannot remember phone numbers and addresses, look up the information, together, in a phone book.) In the event it is decided that a suicide watch should be initiated, the people in the adolescent's network can be contacted and asked to participate.

"On a scale of 1 to 10, with 1 being low and 10 being high, what is the number that depicts the probability that you will attempt suicide?" The higher the number, the higher the lethality.

"Do you use alcohol or other drugs?" If the answer to this question is "yes," the lethality is higher because use of a substance further distorts cognition and weakens impulse control. An affirmative response should also be followed by an exploration of the degree of drug involvement and identification of specific drugs.

"Have you experienced significant losses during the past year or earlier losses you've never discussed?" Adolescents who have lost friends because of moving, vitality because of illness, their family of origin because of a divorce, and so forth are vulnerable to stress and confusion and are usually at higher risk for attempting or completing suicide if they have been preoccupied with such thoughts.

"Have you been concerned, in any way, with your sexuality?" This may be a difficult question to explore, even briefly, during a peaking

suicidal crisis. Generally, adolescents who are, or think they may be, gay or lesbian are at higher risk for suicide. It is difficult for adolescents to deal with the issue of sexual preference because of fear about being ridiculed or rejected. They may have experienced related guilt and stress for a number of years, never daring to discuss their feelings with anyone.

"When you think about yourself and the future, what do you visualize?" A high-risk adolescent will probably have difficulty visualizing a future scenario and will describe feeling too hopeless and depressed to even imagine a future life.

As noted at the beginning of this discussion, it is not necessary to ask all of these questions if the answers are shared during the course of the discussion. It should also be noted that the interviewing team must make judgments about the truthfulness of a specific response by considering the response in the total context of the interview.

10. Make crisis management decisions. If, as a result of an assessment made by at least two professionals, the adolescent is at risk for suicide, a number of crisis management interventions can be considered. They may be used singly or in combination; the actual combination will depend on the lethality determination, resources and people available, and professional judgment. It is the responsibility of the professionals involved, however, to develop a crisis management plan to be followed until the crisis subsides and long-term counseling or therapy can be initiated.

Notify parents. Parents of minors must be notified and asked for assistance when an adolescent is determined to be at risk for a suicide attempt. Often, adolescents may attempt to elicit a promise of confidentiality from a school or mental health counselor who learns about suicidal intent. Such confidentiality is not possible; the welfare of the adolescent is the most important consideration, and parents should be contacted as soon as possible.

Sometimes parents do not believe that their child is suicidal and refuse to leave home or work and meet with their son or daughter and members of the assessment team. At times parents may be adamant in their demands that the school or mental health professional withdraw their involvement. Although such attitudes are not conducive to the management of a suicidal crisis, they are understandable because parents may respond to such information with denial or anger to mask true emotions and cope with apprehensions that perhaps their child's situation reflects their personal inadequacies as people and parents. Because an adolescent at risk for a suicide attempt cannot be left unmonitored, this provides a dilemma for a school or a mental health agency. Because conforming to the wishes of noncooperative parents places the adolescent at even greater risk, steps must be taken despite parental protests.

Although some professionals worry about liability issues in such circumstances, liability is higher if such an adolescent is allowed to leave unmonitored and with no provision for follow-up assistance. Schools and mental health centers should confer with legal counsel to understand liability issues and to make sure that the best practices are followed in such circumstances.

Consider hospitalization. Hospitalization can be the option of choice during a suicidal crisis (even if the parents are cooperating) when the risk is high. An adolescent who has not been sleeping or eating, for example, may be totally exhausted or highly agitated. The care and safety that can be offered in a psychiatric unit of a hospital is often needed until the adolescent can experience a lowered level of stress, obtain food and rest, and realize that others consider the circumstances painful and worthy of attention. In many hospital settings, multidisciplinary teams (physicians, psychiatrists, counselors, social workers, nurses, nurse practitioners, teachers) work to individualize a treatment plan and provide for outpatient help as soon as the need for assistance on an inpatient basis subsides.

Write contracts. At times, professionals may decide that developing a contract with the adolescent may be enough to support the adolescent through a period of crisis and into a more positive frame of mind after which the adolescent would be more receptive to long-term counseling or therapy. Such a contract should be written out and signed and dated by the adolescent and the counselor. The contract can also be witnessed and signed by other professionals, friends, or family members.

Contracts should require the adolescent to:

1. Agree not to attempt suicide;
2. Obtain enough food and sleep;
3. Discard items that could be used in a suicide attempt (guns, weapons, medications, etc.);
4. Specify the time span of the contract;
5. Call a counselor, crisis center, etc., if there is a temptation to break the contract or attempt suicide;
6. Write down the phone numbers of people to contact if the feeling of crisis escalates; and
7. Specify ways time will be structured (walks, talks, movies, etc.).

Organize suicide watches. If hospital psychiatric services on an inpatient basis are not available in a given community and those doing the assessment believe the suicide risk is high, a suicide watch should be organized by contacting the individuals that the adolescent has identified in response to the question, "Is there anyone to stop you?" After receiving instruction and orientation from the professional, family members and friends should take turns staying with the adolescent until the crisis has subsided and long-term counseling or therapy has begun. In the opinion of the authors, it is never a good idea to depend on a family member alone to carry out a suicide watch; it is usually too difficult for family members to retain perspective. Friends should be contacted and included in a suicide watch even though confidentiality, as discussed earlier, cannot be maintained.

Postvention

Systemic. When an adolescent has attempted or completed a suicide, it is imperative, particularly in a school setting, to be aware of the impact of such an event on the "system." Usually, within just a few hours, the fact that an adolescent has attempted or completed suicide is chronicled through the peer group. This could present a problem to the faculty and staff in a given school building because not answering questions students raise can engender the sharing of misinformation or "rumors" and encourage open discussion that could embarrass an attempter upon his or her return.

The following guidelines should prove helpful.

1. The principal of the building in which a student has attempted or completed suicide (even though such an incident is most likely to occur off campus) should organize a telephone network to notify all faculty and staff that a mandatory meeting will take place prior to school the next morning. The principal should share information and answer questions about what happened during such a meeting.
2. Faculty and staff should be instructed to answer student questions that arise spontaneously but should be told not to initiate a discussion of suicide in general.
3. Faculty and staff should be told to excuse students from class if they are upset and need to spend time in the office of the building counselor or another member of a core or crisis team.
4. Parents who are upset by the suicidal incident should be directed to a designated individual to have questions answered. Parents should also be provided with options for counseling whether this counseling is provided by school personnel or referred to members of the mental health community.
5. At times, newspaper and television journalists contact the school for information about both the attempt or the completion and the school's response to the "aftermath." Again, it is important to direct all such inquiries to a designated individual to avoid

the problems created by inconsistency or sharing inaccurate information.

6. If a suicidal attempt occurs prior to the initiation of prevention and crisis management efforts in a given building, it is not a good idea to immediately initiate classroom mental health education even if faculty, staff, and core teams have been prepared and a written policy has been developed. Allow sufficient time to pass to prevent embarrassment to the returning student and his or her family.
7. Be alert to delayed or enhanced grief responses on the part of students prior to the anniversary of a suicide completion. Often students will need an opportunity to participate in a support group with peers or individual counseling prior to and, perhaps, beyond the anniversary date.

Individual and family. As many as 6 to 10 individuals (peers, family members, school faculty and staff, neighbors) may be profoundly affected by a suicide attempt or completion for 1 to 2 years afterwards (Capuzzi, 1988). Adolescents, family, or neighbors may be confused or assume guilt and responsibility for what has occurred and be in great need of assistance. Practitioners need to be aware of the need to provide counseling after a suicidal incident so that others don't become suicidal of dysfunctional in other ways.

One of the biggest mistakes adults make after an adolescent has attempted suicide is to fail to provide for long-term counseling for such an adolescent after a suicidal crisis has subsided. Because the "profile" of a suicidal adolescent is one that has developed over time, it is extremely critical to provide opportunities for "healing" and for overcoming life coping skill deficits that may have been developing over a period of years.

Concluding Remarks

The authors believe that individuals who are interested in working with suicidal youth must obtain more extensive information than that provided in this chapter. In addition, such individuals should obtain supervision from professionals qualified to provide such supervision after observing actual assessment interview and counseling/therapy sessions. Generally, neither assessment, preventive, or postvention sessions should be attempted by anyone who has graduated from a graduate program with *less than* a 2-year coursework and practicum/internship requirement. (In the case of counselors, such a graduate program should follow the standard set by the Council for the Accreditation of Counseling and Related Educational Programs.) In addition, membership in the American Association of Suicidology, participation in workshops and conferences focused on the topic of adolescent suicide, and consistent reading of the *Journal of Suicide and Life Threatening Behavior* and other books and journals are imperative.

Readers should also be cautioned not to use the material in this chapter as the sole basis for mental health education on the topic of adolescent suicide prevention or faculty/staff development in schools. This chapter provides an overview and an excellent starting point for professionals. Those without expertise on the topic or graduate preparation as a counselor, social worker, psychologist, or psychiatric nurse will not be able to answer questions of clients, families, and other professionals on the basis of reading a single chapter on this topic. Finally, anyone reading this chapter should be cautioned against initiating an adolescent suicide prevention, crisis management, and postvention program without writing a description of the various components so it can be checked by other professionals (including attorneys) and followed by all those involved in such an initiative.

An adolescent who becomes suicidal is communicating the fact that he or she is experiencing difficulty with tasks such as problem solving, managing stress, or expressing feelings. It is important for us to respond in constructive, safe, informed ways because the future of our communities (whether local, national, or international) is dependent upon individuals who are positive, functional, and able to cope with the complex demands of life. As research and clinical experience provide additional and more sophisticated information about adolescent suicide, it will be necessary to incorporate this information into prevention, crisis management, and postvention efforts. To abdicate our responsibility to do so would communicate a lack of interest in the youth of the 1990s and a lack of concern about the future of society.

References

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders.* (3rd ed., rev.) Washington, DC: Author.

Bigrar, J., Gauthier, Y., Bouchard, C., & Jasse, Y. (1966). On the depressive illness in childhood: Suicidal attempts in adolescent girls. A preliminary study. *Canadian Psychiatric Association Journal, 11* (Supplement), 275–282.

Cantor, P. (1976). Personality characteristics found among youthful female suicide attempters. *Journal of Abnormal Psychology, 85*, 324–329.

Capuzzi, D. (1986). Adolescent suicide: Prevention and intervention. *Counseling and Human Development, 19*(2), 1–9.

Capuzzi, D. (1988). *Counseling and intervention strategies for adolescent suicide prevention.* (Contract No. 400–86–0014). Ann Arbor, MI: Eric Counseling and Personnel Services Clearinghouse.

Capuzzi, D., & Golden, L. (Eds.) (1988). *Preventing adolescent suicide.* Muncie, IN: Accelerated Development.

Cull, J., & Gill, W. (1982). *Suicide probability scale manual.* Los Angeles: Western Psychological Services.

Curran, D.F. (1987). *Adolescent suicidal behavior.* Washington, DC: Hemisphere.

Davis, P.A. (1983). *Suicidal adolescents.* Springfield, IL: Charles C Thomas.

Ellis, A. (1979). The practice of rational-emotive therapy. In A. Ellis & J. Whiteley (Eds.), *Theoretical and empirical foundations of rational-emotive therapy* (pp. 61–100). Monterey, CA: Brooks/Cole.

Faigel, H. (1966). Suicide among young persons: A review of its incidence and causes, and methods for its prevention. *Clinical Pediatrics*, 5, 187–190.

Hafen, B.Q. (Ed.). (1972). *Self-destructive behavior.* Minneapolis, MN: Burgess.

Hafen, B.Q., & Frandsen, K.J. (1986). *Youth suicide: Depression and loneliness.* Provo, UT: Behavioral Health Associates.

Hussain, S.A., & Vandiver, K.T. (1984). *Suicide in children and adolescents.* New York: SP Medical and Scientific Books.

Jacobs, J. (1971). *Adolescent suicide.* New York: Wiley-Interscience.

Jacobziner, H. (1965). Attempted suicides in adolescents by poisoning. *Journal of the American Medical Association, 191*(1), 101–105.

Johnson, S.W., & Maile, L.J. (1987). *Suicide and the schools: A handbook for prevention, intervention, and rehabilitation.* Springfield, IL: Charles C Thomas.

Kidsrights Catalog. (1989). Mount Dora, FL: Kidsrights.

Kiev, A. (1977). *The suicidal patient.* Chicago: Nelson-Hall.

Kovacs, M., Beck, A., & Weissman, A. (1975). The use of suicidal motives in the psychotherapy of attempted suicides. *American Journal of Psychotherapy, 29*, 363–368.

Krumboltz, J.D., & Thoresen, C.E. (Eds.). (1976). *Counseling methods.* New York: Holt, Rinehart & Winston.

Lazarus, A. (1976). *Multi-modal behavior therapy.* New York: Springer.

McAnarney, E.R. (1979). Adolescent and young adult suicide in the United States—A reflection of societal unrest? *Adolescence, 14*(56), 765–774.

McWhirter, J.J., & Kigin, T.J. (1988). Depression. In D. Capuzzi & L. Golden (Eds.), *Preventing adolescent suicide* (pp. 149–186). Muncie, IN: Accelerated Development.

Otto, V. (1972). Suicidal acts by children and adolescents: A follow-up study. *Acta Psychiatrica Scandinavica, 233* (Supplement), 5–123.

Peck, D. (1983). The last moments of life: Learning to cope. *Deviant Behavior, 4*, 313–332.

Ross, C. (1980). Mobilizing schools for suicide prevention. *Suicide and Life Threatening Behavior, 10*, 239–243.

Schneidman, E., Farberow, N., & Litman, R. (1976). The psychology of suicide. New York: Aronson.

Sommes, B. (1984). The troubled teen: Suicide, drug use, and running away. *Women and Health*, *9*, 117–141.

Stein, M., & Davis, J. (1982). *Therapies for adolescents*. San Francisco: Jossey-Bass.

Stillion, J., McDowell, E., & Shamblin, J. (1984). The suicide attitude vignette experience: A method for measuring adolescent attitudes toward suicide. *Death Education*, *8*, 65–81.

Sudak, H., Ford, A., & Rushforth, N. (1984). Adolescent suicide: An overview. *American Journal of Psychotherapy*, *38*(3), 350–369.

Truckman, J., & Connon, H.E. (1962). Attempted suicide in adolescence. *American Journal of Psychiatry*, *119*(3), 228–232.

Velkoff, P., & Huberty, T.J. (1988). Thinking patterns and motivation. In D. Capuzzi & L. Golden (Eds.), *Preventing adolescent suicide* (pp. 111–147). Muncie, IN: Accelerated Development.

Chapter 12

TOUGH ENOUGH: GANG MEMBERSHIP

Alcena E. Boozer

This chapter examines the youth gang phenomenon. Setting the modern youth gang within the context of history and literature, the discussion includes a consideration of ethnicity as a factor in the organizational structure of gangs. Profiles of youth especially at risk for gang involvement are presented including a case study that illustrates common manifestations of risk factor patterns.

From the information base about gang organization, ethnic composition, and profiles and risk factors, the focus shifts to a presentation of strategies that have been found to be effective by schools that have experienced youth gang violence on their campuses. The chapter concludes with a description of a model for building community coalitions that has developed in Portland, Oregon, and a call for a restructuring of our educational institutions in order to eliminate conditions that contribute to the emergence and growth of youth gangs.

The Gang Phenomenon

Children Killing Children

Citizens of communities in urban areas have difficulty processing such devastating information. Gang involvement—a term that seemed relatively harmless is suddenly a term that produces responses of fear, anxiety, anger, rage and frustration—but mostly fear—fear of violence and fear of intimidation. Gang organization, presence, and activity are not new concepts. A cursory survey of the historical record and literary works testifies to the existence of groups who would meet the criteria established by Jackson and McBride (1987): "A gang is a group of people that form an allegiance for a common purpose, and engage in unlawful or criminal activity" (p. 20). The Legend of Robin Hood was about a gang. Not unlike some gangs operating today, Robin Hood's gang was believed to be helpful by some people in the communities in which it operated. Often modern street gangs first present themselves as "protectors" of the community. Yet Robin Hood's "Merry Men" carried weapons and their behavior, even though they robbed from the rich to give to the poor, was illegal under existing criminal codes of the era.

In 19th-century America, particularly in the West, a number of gangs operated. One of the best known, the Jesse James gang, terrorized a 16-state area. Gang activity, then as now, demanded a response from governmental officials. The governor of Missouri offered a reward for their arrest. In the 20th century groups were also organized to commit illegal and violent acts during the 1920s and 1930s. The best known gangs were active in Chicago and New York. The same violent illegal behaviors of robbery, violent assault, and murder characterized the 20th-century version of the gangster. Neighborhoods were sometimes severely affected as gangs battled each other for territorial control and routinely robbed, beat, or killed people as they sought to instill fear in a community.

By the 1940s the gang activity in the Western part of the United States was most clearly manifested in Southern California in Hispanic communities. Jackson and McBride (1987) described the early California gangs as encompassing street gangs, car clubs, and prison gangs. Although there were known Asian, Black, and Caucasian gangs operating in California from the 1920s on, the Hispanic gangs attracted the most interest of researchers because of the similarity of their internal structure.

> The structure of Hispanic street gangs is similar throughout the Western states. Codes of conduct have been established from which traditions have evolved over generations. These traditions are not written, but are handed down orally from generation to generation and are referred to as 'Moridas.' (p. 31)

One of the most frustrating characteristics of the modern youth gang that has evolved along the West Coast is the undefined nature of its structure. There seem to be no elective offices. One California gang investigator described it to a group of educators and law enforcement officers at a street gang training session meeting in Anaheim in 1987: "The leader is whoever is acting out most violently at a given time" (Boozer, 1987). There is little real internal control over the behavior of individual members and it is difficult to predict their behavior. Observations of gang activity will lead even the novice investigator to become concerned over the relative youth of gang members, given the levels of weapon use and violence. It is common to see 14–16-year-olds who identify themselves as "O.G." (original gangsters) and students as young as 12–13 carrying guns. Personnel from school districts in Southern California have cited the need to begin school-based programs geared toward prevention of youth gang involvement as early as the elementary grades. The city of Pomona presents a program on gang membership in its elementary schools and has added a unit entitled, "The Gang Membership Is Hazardous to Your Life Intermediate School Follow-Up" targeted for seventh graders. Such programmatic responses illustrate the level of community concern about a problem that is threatening the survival of affected neighborhoods and in some extreme cases, cities (Pomona Public Schools, 1987).

Visitors to the Los Angeles city and county area are struck by the pervasiveness of gang behavior. Everywhere, graffiti, the vehicle for mass communication among rival gangs, within gang subsets, and to those who are graffiti-literate in the outside world, serves notice that there is an ever-present threat level. The Los Angeles area recorded more than 350 gang-related deaths during 1987. Law enforcement officers have stated that many whose lives were lost were innocent bystanders, victims of a violent and unpredictable mentality that places loyalty to the gang above any other value. The threat to the greater community is perhaps more clearly delineated when one considers the extent of youth gang activity. It has been estimated that more than 70,000 individuals belong to the more than 300 gangs identified by law enforcement agencies as operating in Southern California (Boozer, 1987).

As Southern California law enforcement agencies responded to escalating levels of violence with more stringent arrest and detention policies and practices, another factor, the drug connection, contributed to the exodus of some of the Black gangs from the area. During the mid 1980s, people identified as members of the Crips and Bloods (Pirus) were observed in the Oakland, California, area and in the Pacific Northwest, most notably in Portland, Oregon, and Seattle, Washington. According to police department reports, the individuals believed to be gang members were arrested for trafficking in drugs, weapons possession and use, and assault and harassment. In the spring of 1987, it was estimated that 50 active gang members were operating in Portland, Oregon (Portland, OR, North/Northeast Youth Gang Task Force, 1987). Initial reports by the news media focused on the two major Black gangs, leading to a perception in some parts of the community that the "gang problem" was a Black problem. Members of the North/Northeast Youth Gang Task Force, who developed community gang awareness presentations, quickly recognized the need to provide information on the significance of ethnicity as a factor in youth gang organizational structures.

Ethnicity as a Factor in Youth Gang Organizational Structures

The Youth gangs that have emerged in cities along the West Coast of the United States reflect the ethnic pattern observed in Southern California.

> Youth gangs in California are usually organized along ethnic lines and are comprised of Asian, Black, Hispanic (Mexican-American or Chicano), and White groups. Although they tend to organize themselves according to ethnicity, the gangs (who constitute a very small segment of the population) are not representative of the ethnic community of which they are a part. (Suarez, 1987, p. 5)

There were 568 known gangs recorded in the 1987 California Gang Investigators' report. Ethnic distribution for the 568 gangs indicates that Hispanics, at 303, and Blacks, at 202, are the groups most heavily represented. Asian gang activity primarily encompasses the Southeast Asian refugee community and represents a small, but rapidly increasing percentage of the total number of gangs. White gangs, at 13, reflect a small percentage of the total (Pottier, 1982). The remaining number includes Samoans, Philippines, and Tongans. If one accepts the premise that young people join gangs to meet needs normally fulfilled through traditional institutions such as the home, church, and school and that, as a result of unequal access to economic opportunities and educational institutions, ethnic minorities have few opportunities to experience success, the overrepresentation of Hispanic and Black young adults in youth gang activity is not an unexpected phenomenon. In assessing the ethnic distribution of youth gang activity in a community, practitioners need to develop an awareness of economic and social issues that must be addressed in order to effectively discourage youth from joining gangs. Although unequal economic opportunity may in part account for the overrepresentation of ethnic minorities in youth gangs, it is important to recognize that gang activity is *not* limited to low-income youth. White gangs often include members from all economic levels (School Safety & Security Management, 1988).

Having established the fact that there is a measurable ethnic distribution of youth gangs that has recently been most intensively investigated in California, it can be now suggested that wherever significant gang activity has been reported, it will be related to the ethnic composition of the community. A comparison of Los Angeles, California, and the Pacific Northwest illustrates how ethnicity is reflected in gang activity. In Los Angeles, where Hispanics represent the largest minority group, the most detailed analyses are those dealing with Hispanic gangs. Conversely in the larger cities of the Pacific Northwest such as Portland, Oregon, and Seattle, Washington, where the Hispanic communities are relatively small, and Blacks make up the largest ethnic minority population, Black gangs receive the most attention from social science investigators and journalists. Concurrent with Black gangs, Asian gangs also are perceived as a major problem in communities where the Southeast Asian refugee community has rapidly increased and is concentrated in specific geographic areas. It has been the experience of cities recently encountering major youth gang problems that any organized response must be undertaken by groups and individuals who possess a thorough knowledge of the cultural experience of those who compose a given gang's membership.

All ethnic gangs mentioned in this discussion meet the criteria established by the California Gang Investigators' (Pottier, 1982) definition of a gang. Differences that can be identified, however, distinguish a gang as unique as a result of ethnicity. Graffiti is a relevant factor of the ethnic gangs cited in this discussion. It serves as a major vehicle for communication within and between gangs in an ethnically distinctive manner.

Graffiti

Hispanic Graffiti

In terms of the modern street gangs (after 1940), the most highly developed graffiti is that used by Hispanic groups. It is highly stylized and structured, requiring much effort to perfect to a level deemed worthy of the work now adorning walls of public and private buildings and structures throughout urban America. Jackson and McBride (1987) identified basic elements of Hispanic gang writing:

> . . . *logo*, a descriptive emblem used to identify the gang. May include Roman numerals, initials, name or symbol; *placa*, name or nicknames of person who puts up the graffiti; assertions of the gang's strength or power; closing example pl v, for por vida, a reference to the length of time the gang will be in control of the turf: forever. (pp. 63–64)

Black Graffiti

To the casual observer, Black gang graffiti, which started appearing in the 1970s, may not seem to differ greatly from Hispanic work. Closer examination reveals differences in style; it has less flair and attention to detail, and the content emphasizes individual prowess rather than gang strength (Jackson & McBride, 1987). Black gangs frequently include statements of intent to harm rival gangs or gang members. Numbers 1,2,3 are often replaced with the terms *ace*, *deuce*, and *trey* (i.e., 52nd street becomes *five deuce*; 83rd becomes *eight, tray or trey*) (Suarez, 1987). Black gangs tend to use graffiti displays to announce their presence in a community and to list the roster of gang members, including real names and street *monikers*. It is therefore a source of intelligence regarding a gang's strength and intentions in a community or school. School administrators and police personnel have found graffiti literacy to be a helpful skill to develop.

Asian Graffiti

Asian graffiti resembles Hispanic more closely than Black in terms of stylization and attention to detail. Most frequently used to claim a territory, it contains little information other than the gang name. Once law enforcement agencies began tracking Asian graffiti in the Northwest, there was a decreased level of activity.

White Graffiti

In 1987 Jackson and McBride and Suarez viewed White graffiti as the work of two groups, the *Stoners* and *White Power Supremacist* groups. Content in White graffiti centers on White racist statements, satanic symbols, or demonic wording and alludes to heavy metal rock music groups. The satanic symbols, upside down crosses with numbers *666* on both ends, and the pentagram are frequently seen. Many words are spelled backwards, for example, "Snatas Srewollof," or Satan's Followers. Stoners select nicknames that connote a demonic nature or violent, antisocial acts (Jackson & McBride).

Distinctive styles of dress among gang members also reflect an ethnic gang style, but one that is not, however, related to a style that can be attributed to ethnic cultural tradition. Gang members may adopt certain items of apparel that are worn in designated colors or in specific ways. (It is suggested that individuals desiring to develop a working awareness of street gangs consult the references noted or contact one of the law enforcement agencies in the Los Angeles area, or Portland, Oregon, for more detailed information.) Members of the Black Crips gang wear items of blue clothing to designate their allegiance. Their arch rivals, the Bloods, display red clothing. The colors differ, but the items that symbolize gang affiliation are the same such as work bandannas, colored shoelaces, and the style of wearing them. The work bandannas are worn hanging out of the rear trouser pockets or tied around the head as a sweatband. Trousers are often worn loosely with the belt line near the mid to lower hip level; such a practice is referred to as "saggin."

In communities where Black gang activity is escalating, involved young people may demonstrate an almost fanatical loyalty to the gang's *color*. Often the presenting indicator of gang activity will be a fight because someone *disrespected* a rival gang's color.

White gangs adapt the types of outfits associated with motorcycle or biker gangs. Favored items include black leather jackets, chains, leather boots, jeans, or military type clothing. Items of clothing are adorned with satan's symbols or names of punk rock and heavy metal groups.

Often young people with no gang affiliation will begin to wear gang-like clothing in an effort to demonstrate readiness and willingness to join a group. School staff and community workers need to keep current vis-a-vis gang apparel. Often an adolescent's abrupt change in clothing style signals the intent to become a "wanna be."

Gang Violence

Ethnic orientation in youth gangs does not automatically result in interethnic gang rivalry and warfare. Most intergang violence is intraethnic. Hispanic gangs tend to fight other Hispanic gangs and Black gangs tend to do battle with other Black gangs. Although not unknown, it is not a common practice for members of one ethnic group to join a gang representing another minority group. Occasionally, a Hispanic may join a Black gang or vice versa. In the early days of the Stoner groups, there were occasional reports of Black members. The limited conflict that does occur on an interethnic basis tends to be between White supremacist groups and individual members of other groups. There is current concern that there will be violent confrontations between Southeast Asian gangs and Black gangs as they battle over control of the drug trade along the West Coast.

From the discussion above, ethnicity is seen to be a factor in youth gang organization in that gangs usually form out of existing friendship/acquaintance patterns in a given community. The frame of reference or world view of the gang members reflects their common heritage and self-perception as individuals who need one another to gain affirmation and acceptance and a feeling of self-worth. As they go through the process of becoming a gang, they build on their most easily identified and basic common traits that set them apart from the rest of the community. Sadly, far too often the factor that most clearly sets a group apart is ethnic identification. This is validated by finding a perverse pride of race in violent confrontation with the power structure in the community, which represents power and privilege that is inaccessible on any other basis.

Profiles of Youth Especially at Risk of Gang Involvement

The youngest gang member to come to this writer's attention was 8 years old when referred for youth gang outreach services. A brief sketch of his experience will help to develop a composite profile of children most severely at risk of becoming involved in a gang. Hezekiah (not a real name) was well known to the staff of the elementary school that he attended. They had known him as a 2-year-old toddler who wandered the streets alone. Older children often brought him into the school where he was fed and attempts were made to contact his mother. Referrals were made to local agencies. Hezekiah was taken from his mother's custody, and a grandparent was appointed as guardian. The grandmother was also guardian for four other older boys who were abandoned by their parents. Although the grandmother expressed the desire to help her five grandsons, at age 63, she no longer had the energy, will, or resources to administer discipline consistently. There were few attempts to do anything for Hezekiah beyond the most basic needs for food and shelter. As indicated above, he was seldom missed when he disappeared from home for hours at a time from the day he learned to toddle along the streets of the neighborhood.

The people on the streets, many of them gang members, became Hezekiah's "family." From them he learned to talk and to become physically aggressive. With gang members as role models, this miniature "O.G." (original gangster) mastered the vernacular and concomitant nonverbal behaviors. The staff at the early childhood education center that he attended referred him to social workers and child development specialists for violent aggressive behavior and inappropriate sexually oriented gestures in the classroom. The primary grades for Hezekiah were times of constant conflict with other children and the school staff. Frustrated by the seeming lack of programs to deal effectively with what was perceived as grossly inappropriate behavior, the principal resorted to out-of-school suspension. Hezekiah learned quickly that when he didn't want to be in school, he needed only to "act out" and the school would send him home—home to the streets where stories of his negative behavior became a source of entertainment to the members of his street family, the gang. This young man was well on his way toward becoming a neighborhood legend. His name appeared in the graffiti around the neighborhood. He organized other children who were poorly supervised into a minigang, whose members armed themselves with baseball bats and started to shake down the neighborhood children. At this point, the school staff contacted members of a newly formed Youth Gang Task Force, a consortium of youth-serving agencies, neighborhood activists, central program school administrators, and juvenile justice and law enforcement personnel. In the conferences and staffings that were scheduled, it was pointed out that in many ways Hezekiah was a classic example of the growth and nurturance of a gang member.

Hochhaus and Sousa (1988), in their study of young gang members ages 13–16, learned from gang members that "Companionship, protection, and excitement—combined with peer pressure—are the most frequent motivations for joining a gang" (p. 75). Hezekiah received little attention in the home of his grandmother. He was abandoned by his mother. The people of the streets, gang members or children who looked to gang members as role models, offered the companionship he needed and sought. This extended street family also conveyed to him a sense of protection. Anybody who "messed with the little dude" would answer to the local gang chieftain. Perhaps most important to Hezekiah, the gang was a source of excitement. As Hochhaus and Sousa (1988) indicated, excitement was a powerful motivation for the boy to join the gang. It served to fill a void in his life with actions that were fun and exciting.

The profile sketched above could serve as a dire predictor of a life as a gang member that would become more and more violent until, most likely before the age of 24, Hezekiah would be either incarcerated or killed. In this case, the subject was diverted from this path by the intervention of one committed individual in Hezekiah's life.

Helping interventions will be discussed in greater detail in sections that follow. At this point other factors that contribute to placing a young person at risk of becoming involved with gang activity will be presented. It will come as no surprise to practitioners in the field of education that factors that place one at risk of gang involvement differ little from those that place a student in any other at-risk category, be it dropping out of school or becoming a teen parent. A general statement that might be applied to help a school staff come to grips with the gang issue is: "busy, successful students do not join gangs." Students who join gangs do not feel competent as learners, are seldom affirmed by anyone of the school staff, and do not feel connected or bonded to the school.

To help identify young people most severely at risk, most recent publications include lists of behaviors, which, when seen in definitive patterns, are believed to be strong indicators of probable gang involvement. "Gangs in Schools," a booklet published by the National School Safety Center (NSSC, 1988) lists the following as warning signs:

- Rumors or reliable information that a youth has not been home for several nights;
- Evidence of increased substance abuse;
- Abrupt changes in behavior and personality;
- Newly acquired and unexplained "wealth" often showered on or shared with peers (anything from sharing bags of candy with younger children to a flurry of more extravagant spending by older youth);
- Requests to borrow money;
- "Hanging around," but being unable to discuss the problem;
- Evidence of mental or physical child abuse; and
- A dress code that applies to a few: i.e., wearing of a color, style, or item of clothing, a particular hair style, and symbols of identification. (p. 10)

Such behavior patterns are most likely to occur among: youth who are from a one-parent home, with the single parent being the mother; families whose income is at or below the poverty level; children who live in a gang-infested neighborhood; or children who have parents or older siblings who are known by law enforcement agencies for criminal racketeering.

Needs That Gangs Meet

In the profile of Hezekiah three needs were discussed and often cited by the participants themselves as needs met by gangs—companionship, protection, and excitement. Gangs also meet the need that all individuals have to be affirmed—as Jesse Jackson says, to be able to say "I am somebody!" Frequently the first to be recruited when a gang comes to town are those who feel that they are "nobodies" in the social milieu of the school community. Magnus Seng (1986), in an article in the *Journal of American Secondary Education*, presented a conceptual framework for gang development in suburban communities. The first stage Seng identified is labeled "A Company of Rejects, a loose collection of individuals each of whom is angry" (p. 10). The "loose collection" includes children who feel set apart for a variety of reasons and may include poor children, the ethnically different, or children considered fat, ugly, or dumb by their peers. "It is in the high school setting that these 'rejects' find each other. They tend to hang out together, to become a loose collection of individuals" (Seng, p. 12).

It is critically important for school staff to be aware of students who make up the "community of rejects." Although they can be found in all schools, their presence does not predestine the school for gang problems. The school community always has the opportunity to intervene with the community of rejects and coax them back into the greater community before they begin to perceive themselves as a gang. This is most easily and effectively accomplished if counselors and teachers accept roles as intervention specialists in the schools' efforts to divert students from youth gang activity. The writer, when working with school staffs on youth gang issues, frequently challenges teachers to think about the most difficult student they have in class, to review the pattern of inappropriate behaviors, and then to weigh them against the ways that they, individually, or the school, collectively, communicate with that student. In how many ways does the school affirm a member of the "company of rejects" is a question that must be pondered daily if we are successfully to convince the community of rejects that they are "somebodies" and that they can experience success in the school environment.

Continuing to think about the needs that gangs meet for children at risk will bring us face-to-face with a major dilemma. How can we compete with the attraction of lots of fast, easy money, which in the eyes of children drawn to gangs is equated with economic security? Gang members as role models are powerful symbols in poorer neighborhoods. They possess the "three Cs"—cars, clothes, and cash. They seem to have the ability to do as they please, intimidating the normal institutions that exercise social control—the schools, churches, and in some cases, law enforcement agencies. Successful programs to counter the economic attraction of gang activity need to include an employment/job training component. Those who staff such programs need to develop an awareness of and appreciation for the perceived economic and physical power of the gang in a given neighborhood. Effective strategies include enlisting the cooperation of former gang members. They can serve as key links between the gang and the community. They are in essence bicultural and have sufficient credibility to persuade and teach gang members, through appropriate language, signs, and symbols, to control their violent behavior (Spengel, 1986). Once violent behavior decreases, gang members are more open to consider alternative avenues toward economic security.

This discussion has touched upon several needs that gangs fill: security, affirmation, protection, companionship, excitement. Most of the needs cited relate to issues of self-esteem, a primary area of interest and concern to school counselors. In terms of needs of children and youth gangs, counselors are in a unique position to help the total school staff assess its ability to work with students in ways that enhance self-esteem. The author hopes that the information presented in this chapter will encourage counselors to initiate programs and activities to deal with those issues in a context that reflects sensitivity to cultural and ethnic factors related to the root causes that make gang behavior seem to be a reasonable response for the poor, the ethnically different, and the less able—all those who compose the company of rejects.

Coming to Grips With Fear, Intimidation, Confrontation, and Violence on the Campus

Schools in communities where even minimal indicators of gang activity are discernible must adopt a policy of assertive vigilance and preparedness. Once a violent act occurs on a campus, a well-designed response plan must be activated to contain the disruptive influence of both the gang and the level of community fear and security resulting from the perceived power of the gang. Essential components of effective response plans include the involvement of law enforcement officials and a detailed communications plan. The National School Safety Center (NSSC) (1988) stressed the need for the plan to "assume constant and consistent communications and designate responsibilities to specific staff members and administrators, in order to get the facts to the proper authorities, parents and general public" (p. 33). It is essential to avoid the sometimes well-intentioned effort to withhold information to "keep the situation under control," or "avoid creating hysteria." People want and need to know what happened and more importantly, they want to know what's being done about it. Specifically the NSSC recommends that schools:

> Have a media policy worked out in advance. Spell out who will be the media contact, and make it clear that no one else will speak officially for the school or school district. Simultaneously keep school employees and students informed. They are going to be unofficial representatives who are going to serve as key communicators in the community. In addition to the written media policy, school security departments need to:

1. *Acknowledge the problem immediately* and get help from local police and community groups.
2. *Educate security personnel.*
3. *Establish informed communication networks* with the kids.
4. *Institute a strict visitors/trespassers policy.*
5. *Control school access points.*
6. *Remove graffiti* as quickly as possible.
7. *Work closely with local police*, especially work to establish procedures whereby information may be shared.
8. *Consider the use of cameras* to take pictures of suspicious visitors or trespassers.
9. *Maintain a high profile*: consider using uniformed security personnel strategically in places to ensure maximum visibility.
10. *Form or access a community network.* (pp. 33–34)

To many educators, taking measures such as those listed above might seem to be the antithesis of what one expects to do in an educational environment. Gang behavior and its associated violence, however, constitute a threat to the educational community such as it has never known. Failure to deal realistically and firmly could result in tragic loss of young lives on our school campuses. The experience of school personnel who have been tested in the crucible of crisis indicates that it is imperative to have a crisis counseling team immediately available to work with students who have been affected by violence on a campus. The crisis team members should be experienced in working with adolescents and have training in the grief counseling process. They should be prepared to, in essence, "wander about the campus," making themselves available to young people who need to talk and need someone to listen. Crisis team counselors need to be equally available to staff members who may need assistance in working through their own feelings.

The Role of the School Counseling Staff in Coordinating School and Community Training Activities

A review of recent literature on youth gangs in schools leaves one with the impression that dealing with youth gangs has become the primary domain of security and disciplinary personnel. There is a strong emphasis on the need to tighten up disciplinary procedures and measures. Although it is not desirable to minimize the need for such containment policies, it is, in the writer's opinion, critical to involve the counseling staff in the planning and coordination of school and community training activities.

As indicated earlier in this chapter, young people join youth gangs to fill needs that are not being met for some marginal students either in the schools or the community. The counseling staff, if permitted the time to work with students individually or on a small group basis, is best suited by training and professional responsibility to engage the students in an intentional process that will enable them to explore their own needs, weigh consequences of gang affiliation, and explore alternative options for fulfilling their needs.

When training or gang awareness activities are scheduled in the community, emotions tend to peak. An approach based on a police, security-oriented rationale tends to polarize communities, particularly those with a history of police/minority group conflict and tension. The potential for new conflicts over how the community responds to gangs can be decreased by processing the information through a counseling-based frame of reference. Counselors should be on the planning team to design a school or district response plan related to youth gangs.

A unique role for the counseling department in the Portland, Oregon, school district's response to youth gangs was to develop and teach a "youth gang awareness" unit in grades 4 and 5. The unit was designed to provide a vehicle for the intervention work necessary to interrupt the cycle of "wanna be" behaviors before they become entrenched and escalate through the stages identified by Seng (1986) from a "gang in embryo" to hard core gangsters. The gang awareness activities dovetail with the self-esteem, drug awareness, and personal safety issues taught by the child development specialists assigned to each elementary (K–5) school. At the middle and high school levels a "violence prevention curriculum" developed in Boston, Massachusetts, is being adapted and will be introduced during the 1988–89 school year. This curriculum focuses on the dynamics of violent encounter, the identification of behaviors likely to trigger or evoke a violent response, and the learning and practicing of behaviors that can defuse such situations. Again, such discussions are natural turf for school counselors.

Educating the Community

When gangs move into a community, one of the first agencies looked to for help is the local school district. Many gang members and those perceived to be gang members are school-aged; an assumption is made that they are enrolled in school, therefore the school is the logical agency "to do something." On lists of things recommended for schools to do, one frequently notes a call to "form a community network or coalition." It will be helpful, for illustrative purposes, to present a case study of the Portland, Oregon, North/Northeast Youth Gangs-Youth Concerns Task Force (1987).

Portland's population of 404,293 contains over 174,000 households. Eighty-seven percent of the population is White, 7% Black, 3% Asian, and 1% Native American. Forty-four percent of the Black population resides in the north/northeast cluster of neighborhoods. The north/northeast neighborhoods have higher crime rates, lower family income rates, and more single-person households than other neighborhoods (City of Portland, OR, 1987). The schools in the north/northeast neighborhoods report more disciplinary suspensions, particularly for Black children. There are fewer economic opportunities available to young men aged 16–25. During the spring of 1987 the schools and neighborhood crime prevention offices began to receive telephone calls form anxious parents demanding to know why their children were afraid to wear certain colors of clothing to school. Puzzled staff members started to investigate the situation. Juvenile court counselors were among the first to verify the presence of known members of Los Angeles-based gangs in North Portland neighborhoods. There were 19 gang-related crimes reported in the city in a 6-week period in the spring of 1987 (Portland, OR, North/Northeast Youth Gang Task Force, 1987). Drive-by shootings were included in the gang-related crimes, causing much heated debate at a series of neighborhood meetings. Neighborhood activists and staff members in the police department of the school district and youth serving organizations, and reporters from local TV stations in the city organized as a youth gangs task force. Members of the task force solicited the support of upper-echelon administrators to send a representative group of 16 people to Anaheim, California, to attend a training conference sponsored by the California Gang Investigators Association entitled, "Street Gang Training for Police and Community Board Organizations" (Boozer, 1987).

Local media provided intensive coverage of the local task force's journey, and the members lost no time in taking advantage of the public attention. A proposal was written and funding was obtained to hire a gang task force coordinator and two neighborhood outreach workers, and install a gang hotline to assist in rumor control. As the task force program was being organized, the agencies represented on the task force initiated their own in-house "anti-gang" programs. At regular meetings agencies were apprised of one another's efforts, and in a number of instances there were joint ventures. Several public presentation teams were organized, and, at the request of civic organizations, churches, and public agencies, gang awareness training was offered to all who wished to become informed. At the time of this writing, the State Human Resources Department management, public utilities management, field personnel, bankers, a variety of professional associations, and school support personnel have completed a gang awareness training program entitled "Gangbusters 101."

The public education component of any community's effort to respond to the challenge of youth gangs is the most critical link. Without an informed community, there will not be the support and pressure on agencies to fund the kinds of intervention, prevention, and enforcement programs needed to save a city's youth from the hazards associated with youth gang membership. The Portland, OR, North/Northeast Youth Gang Task Force case has illustrated that process. As the first signs of youth gang activity were documented, contacts were made with other cities to learn what kinds of strategies had been tried to contain the growth and spread of gang activity. The message received from cities in Southern California was that they had waited much too long to act. Referring back to the Seng model, they had failed to deal with the "company of rejects" and as a result had had to try to deal with each successive level, concluding that at every step they were doing much too little much too late. The message deeply affected the members of the Portland task force. They returned home and started the public information campaign, dubbed by some of them as a Holy Crusade, to save our most precious resource—our children. Politicians in an election year discovered that it was best not to ignore this vocal group that had captured the public's attention and that was committed to using its growing influence "to help our friends and ignore those who ignore us."

Some problems contributing to the growth of street gangs were being debated in Oregon, a major one being a lack of jail space. As an editorial in *The Oregonian* stated, "Word is out on the streets of Portland, Los Angeles, Seattle and Sacramento: In Portland, the "living is easy" for cocaine and crack dealers. The territory's open and the money's big. Law enforcement is handcuffed by the absence of jail space" ("Pull Down Gangs," 1988).

Building Coalitions to Provide Positive Alternatives to Youth Gang Membership

Effective positive alternatives to youth gang membership need to include opportunities for children and young adults to become aware of youth gangs and weigh the consequences of youth gang membership in order to make wise personal decisions about how they will seek to fulfill their personal needs and to build self-esteem. Schools acting in isolation cannot meet those needs. Therefore it is incumbent upon the school staff to establish working relationships with other agencies and institutions in the community and engage in a problem-solving process to generate creative proposals to implement appropriate intervention programs. As indicated in the Portland case study, the first step in building the coalition involves a coming together of staff members who provide direct youth services. People such as juvenile parole counselors, youth service center and recreational center counselors, school counselors, attendance counselors, and neighborhood crime prevention specialists are in the best position to provide accurate information about the level of gang type behavior that may be present in a given neighborhood or community. It is at this level that descriptive documents can be prepared to sensitize mid-level managers and enlist their support for the creation of a community-based task force.

The concept of a community-based task force is a fundamental building block of a coalition to provide positive alternatives to youth gang membership. The targeted group, youth at risk for gang involvement, often have little confidence in the agencies charged to serve them. Such youths have experienced little if any success in school. Their experiences with law enforcement agencies have often not been positive. They have expressed little interest in participating in the activities sponsored by the traditional groups such as YMCA or YWCA, boys clubs, scouts or camp fire, and churches. To reach marginal youth, people involved will have to "speak the language" of the streets. People who speak the language of the streets are most likely to be identified at open forums designated to share information and listen to citizen complaints. At open community forums care should be taken to identify "fringe people." The fringe people operate in both traditional social settings and in the world of the gang members. The affirmation and increased self-esteem they are seeking might be obtained in the emerging community-based task force. They should be included in debriefing sessions following the community forums and invited to participate in the design and development of funding proposals. The inclusion of such individuals broadens the base of the coalition and helps to ensure that the perspective of those most at risk of gang involvement will not be lost in the bureaucratic organizational process that is sure to emerge if public funding is to be obtained.

One of the potential pitfalls of the coalition-building activities is the tendency of neighborhood activists and school agency representatives to polarize around issues of improvement. The activists sometimes feel that gangs emerge as a result of the failure of the traditional youth service/educational agencies to meet the needs of poor and minority children. The agency representatives and educators sometimes grow impatient with the process or become defensive about perceived criticisms of their efforts. At this stage, those school counselors and neighborhood youth counselors who have established a reputation for being able to create and maintain positive rapport with the activist community should be used as facilitators of a series of workshops and retreats. The new coalition can move beyond "hidden agendas" and create a working task force. Such a task force must be capable of motivating and energizing sustained community organization and school-based programmatic efforts. The resultant combined resources will be able to set in place a continuum of activities to identify the students at risk at an early age and to engage them in the educational, social, and economic experiences that will discourage the pursuit of violent, illegal gang activity.

Once the funding proposals have been completed, the individual representatives of the cooperating agencies and community organizations and neighborhood activists need to return to their respective communities to enlist the aid of their upper-level management groups and boards of directors. This is another critical point in the process. Some cooperating agencies will be more responsive than others. The strategic response found to be most productive has been to work with the agencies willing to provide support. The other, less enthusiastic agencies tend to get on board once public attention is focused on the activities of the coalition.

As the public agencies respond, coalition members need to move into the private corporate sector, offering to provide informational workshops, seminars, or luncheon speakers. The private sector, correctly perceiving that increased gang activity has a negative economic impact, often provides significant support for coalition efforts.

An important community to include in the emerging coalition is the religious establishment. The churches, synagogues, and mosques of a community are the natural institutions that provide training and support to young people who are struggling with ethical choices and moral issues. They should be included in the organizational efforts and encouraged to offer activities to help families and children to find productive ways to use leisure time constructively. In some communities, religious organizations have sponsored after-school homework centers or offered space for Saturday school programs. One church in Portland sponsored a program in which children who were out of school on suspension could be supervised and helped with their assignments. Another group is sponsoring a "released-time" religious education program that also offers after-school and weekend recreational activities. Both the school staff and the volunteers from the religious community are careful to maintain the traditional separation between church and state. While maintaining the required separation, they have managed to identify areas of mutual concern and areas where they can complement one another's efforts to enhance the opportunities for children to experience success and affirmation in their lives.

The opportunities for creative cooperation available to a community coalition are limited only by the imagination and ingenuity of its members. The problems associated with youth gangs are frightening and, in a sense, overwhelming. Yet as communities begin seriously to examine what is happening in terms of the quality of life available to the coming generation, they will discover that the greatest gains are sometimes made under conditions of greatest stress. The school, as the institution primarily responsible for the education of the next generation, is faced with situations creating a stress capable of crumbling the whole structure. School staff members are finding the cracks and beginning the repair work to support the existing structure until the time that our new one, which we have been building all along, is complete.

The new structure will have no need for security systems, fences, and armed law enforcement officers. Inside the new structure young people will be nurtured and affirmed in ways that will make it almost impossible to understand that part of the social studies curriculum that talked about the youth gangs of the 1980s and "at-risk children." It is hoped that the historical record for this turbulent time will indicate that the school initiated, encouraged, and cooperated in a community-based program that resulted in the decrease in acting-out behaviors and the disappearance of the violent youth gangs at the turn of the 21st century.

References

Boozer, A. (1987, August). *California Gang Investigators' Street Gang Training Seminar, Anaheim, CA.*

City of Portland, OR. (1987). *1986 neighborhood information profiles.* Office of Fiscal Administration, Revenue and Policy Analysis Division, 1220 S.W. 5th Avenue, Portland, OR.

Hochhaus, C., & Sousa, F. (1988). Why children belong to gangs: A comparison of expectations and reality. *The High School Journal, 75,* 74–77.

Jackson, R., & McBride, D. (1987). *Understanding street gangs.* Sacramento, CA: Custom Publishing.

National School Safety Center. (1988). *Gangs in schools: Breaking up is hard to do.* National School Safety Center, Pepperdine University, Malibu, CA.

Pomona Public Schools. (1987). *The gang membership is hazardous to your life intermediate follow up.* Unpublished curriculum activity, Pomona, CA.

Portland, OR, North/Northeast Youth Gang Task Force. (1987, May). *Minutes from community meeting, Portland, OR.*

Poitier, M. (1982). *California gang investigators' report.* Paper presented to California Gang Investigators at Los Angeles, CA.

Pull down gangs' colors. (1988, June 20). *The Oregonian*, p. C-4.

School Safety and Security Management. (1988, July). *Special issue: Gangs, guns, drugs: They're here*. School Safety Center, Pepperdine University, Malibu, CA.

Seng, M. (1986). Gang development in suburban communities: The role of the high school. *Journal of American Secondary Education, 18*, 12–16.

Spengel, I.A., (1986). The violent gang problem in Chicago: A local community approach. *Social Service Review, 60*, 96–100.

Suarez, J. (1987, August). *Hispanic street gangs*. Report presented at Los Angeles Police Department Gang Activities Section, Street Gang Training Seminar at Anaheim, CA.

Chapter 13

"WHY SAY NO?": SUBSTANCE ABUSE AMONG TEENAGERS

Sharon E. Robinson

One of the most challenging problems facing society today is the use and abuse of chemical substances by teenagers. In addition to cigarettes, teenagers use many illicit chemical substances such as alcohol, marijuana, cocaine, and inhalants. Abuse of these substances often results in harm not only to the individual teen but also to society. For instance, research has shown that the use of alcohol is associated with 60% of all murders, 40% of all assaults, and 33% of all rapes and child molesting (Department of Health and Human Services, 1984; Tinklenberg, 1973). Our criminal justice system as well as our health care system are experiencing the exploding impact of substance abuse. Millions of dollars are spent yearly in hospitals and special treatment programs to treat crises. In October 1986, the Drug-Free Schools and Communities Act was passed, and the Department of Education received $200 million for drug abuse education in the schools (Business Research Publications, 1987).

The questions we all face are: Who are the adolescents most at risk for substance abuse, and what steps can be taken to prevent or to stop teen substance abuse? Neither of these questions is easily answered. As an initial step in understanding the magnitude of and the issues involved in substance abuse, it is imperative to examine adolescent substance abuse from a variety of perspectives—psychosocial, historical/legal, and psychophysiological. The role of schools, parents, and treatment programs must be addressed as well.

Prior to beginning a discussion of these issues, I would like to emphasize two things. The first is that drugs, in and of themselves, are not good or bad, and second, drug use is not necessarily the same as drug abuse. What influences our value judgments about the positive or negative effects of certain chemical substances is who takes them, for what purpose, when and where they are taken, and how much and how frequently they are taken. For example, a successful business person having a nightly cocktail before dinner to unwind from a hectic, demanding job is not an unusual scenario in American society. In contrast, we would be very concerned about a 14-year-old who has a drink or two because his or her days are stressful. Whereas one situation is viewed as relatively benign, the other can be viewed as "bad" and the user at risk for abuse.

In addition to alcohol and cigarettes, almost all adolescents have been exposed to illicit drugs, and a high percentage have experimented with them. According to Borton (1983), half of all seventh graders have been pressured to try marijuana. By 12th grade, about 57% have given in to this pressure (Johnston, O'Malley, & Bachman, 1984) and 5.5% use it daily. These statistics do not take into consideration those who have dropped out of high school and are even more likely to have used drugs.

Use rates among seniors for other substances "used at some time in their life" include: alcohol (93%); stimulants (27%); cocaine (16%); hallucinogens (15%); sedatives or barbiturates (14%); inhalants (14%); tranquilizers (13%); opiates (non-heroin) (10%); LSD (9%); and amyl and butyl nitrates (8%) (Beschner, 1986, p. 2). Despite these statistics on the types of drugs used, we still understand very little about the adolescent substance user.

Psychosocial Perspective

Jalali, Jalali, Crocette, and Turner (1981) classified adolescent users as experimenters, compulsive users, or floaters. Floaters alternate between experimenting with drugs and being compulsive users. Although experimenters may try drugs out of boredom or curiosity, in the hope of having fun, or in response to peer pressure, they typically use drugs in small amounts and infrequently. Usually they try only alcohol or marijuana and are aware of the difference between having fun and getting into danger. Typically these teenagers do not develop serious drug problems.

A few unlucky teens, however, will become compulsive users, and their lives and health will be at risk due to their drug abuse. For these youth, drugs are an escape. Generally, they have poor relationships with their parents, with their conventional peers, and with school personnel, and have strong relationships with drug-using peers (Dembo, Blount, Schmeider, & Burgos, 1985). These youth often experience self-derogation, depression, and alienation, which are acted out as rebelliousness, aggressiveness, independence, and risk-taking behaviors aimed at sensation seeking (Dembo et al.). More and more of their time and energy is devoted to getting high, and they become connoisseurs of street drugs (Beschner, 1986). Although the data are not exact, it is estimated that between 4% and 5% of teenagers between the ages of 15 and 19 use illicit drugs regularly. This represents about one million teenagers—a staggering number.

According to the literature review by Dembo et al. (1985) on the etiology of drug use, of these one million, the user who is White is most likely to be using alcohol or marijuana. Ethnic minority youth (Black, Native American, and Hispanic) are more likely to use alcohol and drugs other than marijuana. Although no gender and socioeconomic differences seem to exist, use seems to escalate until around age 19, when a decline occurs. The earlier use starts, the greater the potential for deviant behavior, self-derogation, and feelings of rejection by family and peers. In response to feeling rejected, adolescents seek a social climate that accepts and supports drug use and tolerates or endorses crime and other socially deviant behaviors.

This is the extreme scenario, but many youth are rapidly moving toward the compulsive user status. Still, many have been able to stay "clean" or have merely experimented with a substance and have not become regular users. Research is just beginning to address the psychosocial differences between these groups and why some become abusers and others do not.

Historical and Legal Perspective

The use of drugs has not always been considered problematic. Indeed, a review of the political and legislative history of drugs reveals that substance abuse among adolescents is a relatively recent problem. In the early 1800s, the only law America had that regulated drug sales and use was the excise tax on whiskey Congress passed in 1791. Although a regulatory tax was placed on imported opium in 1842, by 1875 opium dens were flourishing and there were reports that the young women and men from respectable families were being ruined. In 1875 San Francisco and in 1882 New York passed laws prohibiting the smoking of opium. The federal government passed an act in 1890 stipulating that only American citizens could import opium. Although this act did not make opium smoking illegal, it did protect the national economy. This tendency seems to have influenced drug regulation policy ever since.

By 1914 it was estimated that 1 in every 400 Americans was addicted to opium or its derivatives. Leading the fight against narcotics use, Dr. Alexander Wright drafted the Harrison Act, which outlawed heroin and put medical controls on other opiates and cocaine. In 1919 the Supreme Court upheld the Narcotics Division decree that providing any narcotic to an addict was not a legitimate medical purpose, and physicians who did so were to be arrested. Between 1919 and 1929, 75,000 narcotics arrests were made and 25,000 among these were physicians and druggists (Ray & Ksir, 1987). To protect themselves, those in the medical professions began to refuse to treat addicts.

Although several local governments opened special clinics to supply legal narcotics, they often were staffed with untrained society-lady volunteers who were unfamiliar with narcotics and the culture of the poorer communities where the clinics were placed. As a result, young men who were not addicts often entered the clinics to obtain a legal dosage of the narcotic and then proceeded to sell their dosage to addicts waiting to get into the clinic. This environment fostered the beginning of the drug black market. Because addicts could no longer get their drugs legally, this illicit drug trade began to flourish, and drugs were sold for 50 times the legal medical price.

During this period, Richard Pearson Hobson, who had gained a national reputation as "Prohibitionist Hobson," warned of demonic drug pushers and created the myth of the dope fiend. His speeches and writings on teenage addiction lead to the passage of the Marijuana Tax Act in 1937, which brought marijuana under the same legal control as narcotics, with the same criminal penalties for sale or possession. Harry Anslinger, who had been appointed director of the Federal Bureau of Narcotics in 1932, claimed that marijuana was the "assassin of youth" and that it caused insanity, murder, rape, and impotence (Mandel & Feldman, 1986). One of his most memorable images was of "rosy-cheeked, innocent girls, lured to inner-city neighborhoods by a misguided sense of excitement, waking up after smoking marijuana for the first time with the realization that they had been debauched by lower-class males" (Mandel & Feldman, p. 23).

Heroin gained popularity among inner-city White youths in street gangs, and the young addict of the 1950s looked and behaved like the dope fiend earlier described by Hobson. To counteract the growth of heroin use, the Narcotics Drug Control Act of 1956 mandated tough penalties for every offense except first-offense possession and sanctioned the death penalty for anyone caught selling heroin to a minor.

With the 1960s came a shift in the type of drug used and a corresponding increase in drug usage. The 400 experts who participated in the 1962 Kennedy White House Conference on Drugs coined the term "drug abuse," indicated that the drug field was characterized by inadequate information and misinformation, supported the use of civil commitment to allow medical treatment of drug abuse, and fostered the initiation of projects to address the social problems of delinquency and poverty.

Between 1964 and 1970, youths across America were becoming drug conscious. Studies on LSD were conducted at Harvard, marijuana was openly smoked on many college campuses, and for the first time there were active pro-drug advocates (Mandel & Feldman, 1986). Drugs were used for "getting in touch" with one's self, for improved socialization, and for enhancing one's senses and realms of awareness. Young middle-class White youth had discovered the "information gap" (which some called the generation gap) between the reality of drugs and what they had been told (Mandel & Feldman).

This was the period of the civil rights movement, sit-ins, freedom rides, mass demonstrations, and the beginning of the Vietnam War and draft resistance. Four students were killed by the National Guard during an antiwar demonstration at Kent State University. Students battled with police at Berkeley, and at Jackson State University police fired on students who were demonstrating against discrimination. The larger conventional culture showed that it was willing to use force to control youth, protests, and drug use.

By 1970 the flower children of 1967 had trouble handling the drugs they had played with, and many were now burned-out speed freaks or heroin addicts. New drugs were hitting the streets and their potency and effects were unknown and often frightening. There were overdoses, admissions to emergency rooms, and bad trips. Between 1963 and 1969 the arrest of teens under the age of 18 for drugs increased fourfold. There was a drastic increase in arrests among Whites, and inner-city minority youth shifted away from using heavy addicting substances to more controlled use of drugs. There was a flagrant "disregard of drug laws by large numbers of young people who were not all members of the under privileged and criminal classes" (Ray & Ksir, 1987, p. 42).

In 1969 Richard Nixon proclaimed a "War on Drugs" and increased the federal anti-drug budget from $40 million in 1969 to $750 million in 1973. Half of this was to go to law enforcement and half to treatment programs. The War on Drugs was an uphill battle, with drugs about equal to alcohol in popularity among adolescents. In many ways the use of drugs had been normalized and no longer was seen as deviant behavior by youth. During each year in the 1970s, however, 49% to 57% of those arrested for drugs were under the age of 21. Arrests for marijuana varied from 62% to 72% of teenagers, with the arrest rates remaining highest for Black men (Mandel & Feldman, 1986).

The present law of the land is the Controlled Substances Act of 1970. Besides expanding the role of community mental health centers and public health service hospitals in the treatment of drug abuse, it authorized the development of drug education materials and workshops for professionals as well as school personnel. It also established maximum penalties for manufacturing/distributing and for possession of drugs categorized into five schedules. For example, a second offense of selling cocaine entails a maximum prison term of 30 years, a fine up to $50,000, and 6 years' probation after release from prison (Ray & Ksir, 1987).

The drug-related arrest rates among young Whites is declining. In 1983 it was approximately half of the 1978 rate. In their study of seniors' use rates between 1975 and 1983, Johnston et al. (1984) reported decreases both in use of marijuana in the last 30 days (in 1978, 37% responded in the affirmative and in 1983, only 25% answered in the affirmative) and in the daily use of marijuana (11% in 1978 and 5.5% in 1983). Similar decreases were found in the use of sedatives, inhalants, tranquilizers, and hallucinogens. In contrast, the use of cocaine and stimulants has increased steadily.

Cocaine has become the drug of the 1980s. Until recently, "coke" was considered reasonably safe and nonaddictive and seemed to be the drug for a health conscious, upwardly mobile, politically conservative generation. That cocaine is not safe has been verified by the deaths of comedian John Belushi and basketball star Len Bias. The criminal penalties for selling cocaine demonstrate a get-tough attitude. That our society disapproves of drugs and is willing to enforce drug laws is evident. Although youth may not be alarmed at someone smoking a joint or possessing several ounces of marijuana, the *Hutto v. Davis* (1982) ruling testifies to the feeling of those representing the nation. Davis was arrested for possession of 9 ounces of marijuana, was convicted on two counts of possession with intent to sell, and was sentenced to 40 years in jail. He appealed his sentence as being cruel and unusual punishment, but the U.S. Supreme Court ruled against him (Inciardi, 1986).

It is evident that everyone should know the drug laws of his or her state. For example, growing marijuana in the privacy of your home is legal in Alaska but can result in a 2-year prison term and a $500 fine in Delaware. The local library is a useful resource for state criminal codes and local drug laws. In addition, teens and their parents need to be aware of the rights of minors when arrested. As a result of *In re Gault* (1967), juveniles have a right to a notice of the charges, a right to counsel, a right to confront and cross-examine witnesses, privilege against self-incrimination, a right to a transcript of the legal proceedings, and a right to an appellate review. Minors do *not* have a right to bail or to a jury trial.

The Psychophysiology of Drugs

Beyond knowing how drug abuse has become such a prevalent social problem and how our legal system is attempting to control drug use, to be at all knowledgeable about substance abuse one needs to have a basic understanding of how drugs affect the body. No matter what drug is taken—aspirin for a headache or cocaine to feel high—the drug must go through several phases. First, it has to be taken into the body, or *absorbed*, and then it is distributed, or *transported* to the part of the body where it will produce its effects. The drug then combines with the body part to exert its *action*. The body then *metabolizes* the drug, which stops its action, and finally, the drug is *excreted*. For some drugs these five phases occur in a predictable manner and in a short period of time. For other substances, the process is erratic and can occur over an extended time period. This is particularly true when one considers a drug's half-life.

Drugs are taken into the body in several different ways, the most common being orally. When drugs are swallowed, they are absorbed through the intestinal walls into the bloodstream. Alcohol, sedatives, and barbiturates, for instance, are taken orally. Marijuana, nicotine, and inhalants are smoked/inhaled and enter the bloodstream through the lungs. Heroin is injected directly into the vein. Snorting is the preferred method of taking cocaine, which is then absorbed through the mucous membranes.

The blood carries drugs to all parts of the body. Because *all* drugs have side effects, we cannot be exactly sure what physiological and behavioral reactions will result from taking a drug. We do know that the effects of a drug depend on many variables including the type, potency, and purity of the drug, the contaminant used to cut the drug, the personality of the user, and the social environment in which the drug is taken. Also, an individual's physiology must be considered, especially the nervous system.

The nervous system is made up of the central nervous system (CNS), the somatic system, and the autonomic nervous system (ANS). The CNS is composed of the brain and the spinal cord and is responsible for such activities as information processing, memory, learning, and activity coordination. Sensory nerves come into the CNS and motor nerves go out. The somatic system interacts with the CNS and controls "voluntary" actions. In contrast, the ANS, which is made up of the sympathetic and parasympathetic systems, controls "involuntary" actions such as heartbeat, digestion, and breathing. Most psychoactive drugs have a significant direct influence on the ANS (Ray & Ksir, 1987).

The chemical messengers that carry information throughout the body can be classified as hormones or neurotransmitters. Our glands release hormones directly into the blood, and neurotransmitters serve as signals within the CNS. How drugs affect hormones can be illustrated in the relationship between the pituitary gland and urination. To help the body maintain homeostasis, the pituitary releases vesopressin when there is a drop in blood pressure. Vesopressin causes the kidneys to release less urine. When alcohol is introduced into the body, the release of vesopressin is inhibited and the amount of urine released by the kidneys is increased. It is this chemical process that causes us to have to go to the bathroom so frequently when we are consuming alcohol, not only because we are drinking liquids. It is also worth noting that in this example, because alcohol causes a decrease in blood pressure, the total decrease in blood pressure is compounded.

Although drugs do affect the actions of hormones, they exert their major impact on the neurotransmitters and their chemical pathways in the CNS. The major neurotransmitters affected by psychoactive drugs are acetylcholine, norepinephrine, dopamine, serotonin, GABA, and endorphins. These neurotransmitters function at the synapse between the axon of one neuron and the receptors of a second neuron. Chains of neurons form the chemical pathways in the brain that are affected by drugs (Goldberg, 1982). Just as different neurotransmitters are affected differently by different drugs, so are parts of the brain. Drugs disrupt neural transmissions; however, the exact process for many drugs is a matter of speculation (Lewis, Dana, & Blevins, 1988).

A brief overview of some of the major structures of the brain might help to clarify the intricate interactions among drugs, neurotransmitters, the brain, and behavior. These structures are (Ray & Ksir, 1987):

1. Cerebral cortex—controls reasoning, language, and sensory discrimination;
2. Basal ganglia—maintains good muscle tone;
3. Hypothalamus—involved in feeding, drinking, temperature, and sex;
4. Limbic system—involved in emotions, physical activity, and memory for location;
5. Medial forebrain bundle—pleasure center; tells us when something feels good, i.e., orgasms;
6. Brainstem—vomiting and respiratory center; and
7. Medulla oblongata—seat of aggression.

When the chemical pathways in these various regions of the brain are invaded by drugs that excite, inhibit, or block the actions of a neurotransmitter, the brain and related behaviors are influenced. For instance, cocaine is believed to block the reuptake of norepinephrine and dopamine at the receptors, and the prolonged presence of norepinephrine in the synapsis elevates mood, producing a feeling of euphoria.

Although research on the interaction of drugs, neurotransmitters, and behavior is just beginning to uncover these complex relationships, we do know that psychoactive drugs affect the chemical pathways. In the basal ganglia, tranquilizers block the reuptake of dopamine, and abuse can result in muscle rigidity. Similarly, dopamine in the medial forebrain bundle is affected by psychoactive drugs and increases one's sense of experiencing pleasure. Nerve gas inhibits the metabolization of acetylcholine, which can cause respiration to slow or to cease (the brainstem is the primary site of action). Under the influence of PCP or angel dust, violent and bizarre aggressive behaviors often occur. This reaction may be due partially to the interaction of the angel dust with the neurotransmitters in the medulla oblongata.

It is evident that drugs do not simply make one feel better. They interfere with the normal functioning of the nervous system as well as other organs in the body. When drugs are abused and overused and when drugs are combined, the effects can be deadly. The two greatest dangers are respiratory failure and cardiac arrest. Those who combine alcohol with sedatives, barbiturates, or tranquilizers are particularly at risk for respiratory failure—they will just stop breathing. No drug is free of toxic effects; some are minor but others are deadly (Julien, 1978).

The point being made is that to be a wise user of drugs, if one chooses to use drugs, then one should be aware of the multiplicity of effects they create. Every drug has side effects, but research has not yet discovered the many influences these side effects can have physiologically or psychologically.

Individual Drugs

Now that a variety of perspectives on the global problem of substance abuse have been presented, it is time to focus on some of the drugs that are abused by adolescents. The three chosen for a brief overview are alcohol, marijuana, and inhalants.

Alcohol

As previously noted, alcohol was the first drug regulated in the United States. America's one attempt at alcohol prohibition in 1920 failed because many citizens obtained alcohol illegally. The Eighteenth Amendment, the Prohibition Amendment, was repealed in 1933. The trend has been to relax the laws on intoxicating beverages; however, with the steady increase in death due to driving while intoxicated (DWI), Congress authorized the withholding of federal highway funds from any state that did not raise its legal drinking age to 21 by 1986.

The two alcoholic beverages most heavily consumed by Americans are beer and wine. It is estimated that 24 gallons of beer, 2 gallons of distilled spirits, and over 2 gallons of wine for each man, woman, and child are sold per year, with sales of wine steadily increasing (Ray & Ksir, 1987).

As Schonberg and Schnoll (1986) pointed out, alcohol and marijuana are the drugs most frequently abused by adolescents. In 1983 at least 93% of a large national sample of seniors reported having drunk alcohol, 5.7% indicated daily drinking, and 41% claimed occasional binging (Johnston et al., 1984). It is an established fact that DWI is the leading cause of death among teenagers. Alcohol abuse is a major teen substance abuse problem.

When consumed, alcohol functions as a depressant. Because it is almost completely metabolized and the rate of oxidation is slow, alcohol has a long duration of action that cannot be controlled (Ray & Ksir, 1987). When the blood alcohol level (BAL) is .05%, there is lower alertness, relaxing of inhibitions, impaired judgment, and usually a sense of feeling good. As the BAL increases, judgment ability declines, reaction time is slowed, and both sensory and motor capabilities are impaired. Intoxication is officially reached at .20 BAL, stupor is reached at .30, and .35 is the minimal level that can result in death from intoxication (Ray & Ksir, 1987).

Like any depressant, alcohol affects the CNS, and in large doses can cause respiratory failure and death. It is also known that the vomiting reflex (controlled by the brainstem) can be activated at .12% BAL unless the drinking is slow and steady, which causes a depression of this reflex. Along with these and other brain changes, there are also cognitive and behavioral changes. There is a lower level of blood flow to the brain, which lowers levels of oxygen, nutrient use, and waste removal. In addition, changes in cortical functions result in behavioral changes. The more rapid the intake of alcohol, the greater the behavioral changes as one becomes less inhibited.

When a woman drinks heavily during pregnancy, the unborn baby can be at risk for fetal alcohol syndrome, which causes physical and behavioral abnormalities in the fetus. Among women who are heavy drinkers, spontaneous abortions are twice as likely (Ray & Ksir, 1987).

Physical damage due to alcohol use is rare in adolescents only because they have probably not been abusing for a long enough period of time. With prolonged abuse, however, gastritis with hemorrhaging and inflamation of the pancreas can result (Schonberg & Schnoll, 1986). Bleeding, severe vomiting, and changes in the blood can necessitate hospitalization. Chronic alcoholism in adults can result in chronic liver disease, inflammation of various nerves, and impaired memory (Schonberg & Schnoll). Withdrawal symptoms for teens who have been heavy alcohol users include perspiring, agitation, brief seizures, tremors, and disorientation.

Alcohol abuse is currently the most significant substance abuse problem among adolescents. It negatively affects cognitions, behaviors, and one's body, and has been linked to increased crime, violence, and suicide. Heavy drinking by teens who are pregnant can be dangerous for the baby and for the teenager herself.

Marijuana

Although marijuana is about equal to alcohol in popularity, even less is known about its effects. From 1937 to 1971 it was legally classified as a narcotic, and in large doses, it can produce hallucinogenic effects. Since the late 1960s, however, society has been far more concerned with the more potent and dangerous substances appearing on the black market than with marijuana.

Marijuana and hashish come from the cannabis plant and get their psychoactive effects from THC (tetrahydrocannabinal). Grades or types of marijuana include regular marijuana, which is 2% to 5% THC, sensimilla, which contains about 8% THC, and hashish, which can be up to 50% THC if made into hash oil.

When marijuana is smoked, the THC is rapidly absorbed into the blood. While producing a sedating effect and causing an enjoyable, dreamy high, marijuana is thought to alter the metabolization of serotonin and dopamine. Schonberg and Schnoll (1986) cited considerable research on the negative effects of marijuana on brain, cardiovascular, pulmonary, endocrine, and psychological functioning. Causing short-term memory loss and depressing one's ability to learn, marijuana smoking has been linked to the "amotivational syndrome" where smokers are lethargic, lack motivation, and are content to do nothing. This becomes a special concern for youth who use marijuana before or during the school day in that they are impairing both their desire and ability to learn. The long half-life of marijuana means that a daily smoker may be continually high because the marijuana is never out of the system, and this further contributes to the amotivational syndrome.

Many of the effects of smoking marijuana are similar to those of drinking alcohol. In addition to red eyes, there are lowered secretions of sex hormones, impaired motor coordination, reaction time, and sensory perception, and decreased ability to follow moving objects. With the poorer motor coordination and distorted time and distance perceptions, driving under the influence of marijuana presents the same safety risks as driving under the influence of alcohol. In fact, marijuana use is considered by many to be the second leading cause of death or injury in car accidents among adolescents.

Although there is no current research to indicate that a physical addiction to marijuana occurs, this may be because the existing research on the effects of marijuana is in its infancy. There is increasing belief that marijuana affects the lungs in a manner similar to tobacco, which often results in cancer. Chronic smoking of marijuana does impair air flow in and out of the lungs, and only long-term research will be able to verify the relationship between marijuana smoking and cancer.

There are many advocates for marijuana, and also many who believe they should publicize every evil related to marijuana, whether backed by research or not. Initial research has shown that its effects are not harmless, but neither are they devastating, and that the primary concern is for women using marijuana during pregnancy and for the psychosocial, educational, and physical development of adolescents who engage in daily heavy use. As Ray and Ksir (1987) pointed out, there is no area of science where emotion about the issue has played such a heavy and influential role as in the smoking of marijuana.

Inhalants

Young adolescents between the ages of 11 and 15 are the primary users of inhalants, although use of inhalants has steadily declined with the increase of marijuana use. Airplane glue, gasoline, cleaning fluids, and aerosols are the compounds these young teenagers sniff. Each of these compounds contains volatile hydrocarbons that cause a strong short-lived euphoric high. Symptoms of inhalant use include "lack of coordination, restlessness, excitement, confusion, disorientation, difficulty in walking (ataxia), delirium, and coma" (Schonberg & Schnoll, 1986, p. 54). While repeated use can result in giddiness, dizziness, and hallucinations, long-term use can cause brain, liver, kidney, and nerve damage (Schonberg & Schnoll).

A syndrome called "sudden sniffing death" can occur when inhalant abuse is immediately followed by excessive exercise and stress. Although young teens may enjoy the giddy high that is connected with sniffing, they are again playing with a potentially dangerous substance.

Prevention and Education

What most concerned adults are asking themselves is how they can intervene to prevent teenagers from using drugs and how they can intervene to decrease or stop substance abuse that is already occurring. Two primary milieus for prevention/intervention are schools and the family. In addition, a variety of treatment programs address substance abuse.

Schools

The primary responsibility for substance abuse prevention and education has fallen on the public schools. Yet, research (Goodstadt, 1980) has shown that just giving students drug education and information (often misinformation) has failed to deter drug use. During the 1970s, educators tried to fight drug abuse by employing affective education through the use of such approaches as Parent Effectiveness Training (Gordon, 1970), the DUSO Kit (Dinkmeyer, 1973), and the Magic Circle technique (Ball, 1974). These seemed not to have had a significant positive impact on adolescent drug use. In 1982, Horan and Williams were able to demonstrate that general assertiveness training and drug-specific assertiveness training positively influenced junior high school students' willingness not to use alcohol and marijuana. At a 3-year follow-up, these students reported less actual drug use and demonstrated higher levels of assertiveness.

A variety of educational programs that attempt to address the teen drug problem have evolved in the last decade. Nancy Reagan is the prime mover for the "Just Say No" approach, which tells kids just to refuse to even try drugs. This, however, is a narrow approach to a multidimensional, complex problem.

Research on the effectiveness of the "Here's Looking at You Two" curriculum that emphasizes increasing self-esteem, reducing peer influence, and providing drug information has been promising (Swisher, Nesselroade, & Tatanish, 1985). Unlike the Here's Looking at You Two curriculum, most other curriculum packages either are not supported by empirical research or have not been systematically evaluated. A few of the drug intervention/prevention curricula that are commercially available include: Children Are People; All Stars; 8:30 Monday Morning; Dare; Lions/Quest Program—Skills for Adolescents; Project Pride; and Get High on Yourself. Most of these attempt to address the drug problem from multiple perspectives. In addition, groups such as Mothers Against

Drunk Driving (M.A.D.D.) and Students Against Drunk Driving (S.A.D.D.) have become increasingly active in the fight against drugs.

Regardless of the school curriculum chosen or locally developed, it would seem appropriate that it attempt to address what research has consistently shown to be the primary factors in the etiology of substance abuse. These factors are peer use of illicit substances (Kandel & Yamaguchi, 1985), peer pressure (Brook, Whiteman, & Gordon, 1983; Brook, Whiteman, Gordon, Nomura, & Brook, 1986), early antisocial behavior (Hawkins, Lishner, & Catalano, 1985), troubled families (Hawkins et al.; Shore, 1985) and deficient intrapersonal qualities such as positive self-concept. Incorporating these should enhance prevention efforts.

The Family

The role of the family in adolescent drug abuse has been widely recognized. Certain family characteristics place an adolescent at risk. Some of the most documented are the abusive family, the alcoholic family, a single-parent family, a family where the children are latchkey children, a blended family, and a family with inconsistent limit setting and rules for behavior.

Substance abuse does not occur suddenly. It is often the result of many factors including feelings of low self-esteem and inadequacy, ineffective coping skills, and poor decision-making skills. Most parents try to raise their children with love and caring; however, too many teens have not learned to love themselves and to cope with life's problems in a constructive way, and instead turn to drugs to escape their problems. Glickman and Utada (1983) found a dramatic degree of conflict, misunderstanding, and disagreement between teens who were seriously involved in drugs and their parents. These teenagers reported that their parents objected to their friends (77%), were disappointed in them (69%), complained about them (64%), and did not trust them (63%). For these teens, the quality of their relationship with their parents was poor and communication was defensive and certainly not honest.

If parents suspect that their child is using drugs, the National Institute on Drug Abuse (NIDA) (1984) advised parents to tell the child about their concern and why the drug is harmful. In addition, they need to communicate that they are opposed to any drug use and that they intend to enforce that position. Parents need to be: "*Understanding* (I realize you're under a lot of pressure from friends to use drugs); *Firm* (As your parent I cannot allow you to engage in harmful activities); *Self-examining* (Are my own alcohol and drug consumption habits exerting a bad influence on my child?)" (NIDA, pp. 4–5). What parents should not be is sarcastic, accusatory, sympathy-seeking, and self-blaming.

because these behaviors tend to make a child defensive and likely to tune the parent out (NIDA).

A confrontation with a child regarding drugs can be difficult and charged with emotions; however, parents can control this by remaining calm, open, loving, and firm. Parents need to listen to their children and not only give advice. One of the keys to helping a child grow up is to teach the child how to make responsible decisions, to accept the consequences of those decisions, and love themselves. This cannot be accomplished quickly but is a slow process that is nurtured by parental support, love, concern, and understanding. Parents need to know the difference between firmness and punishment. Children respect fair limits that take into consideration their maturity and behaviors. Consistency in limit setting helps a child understand the acceptable parameters for behavior and what will consistently earn approval or disapproval. Parents need to be in charge in a loving, supportive manner. Although adolescence is a time of seeking independence, autonomy, and self-identity, most teens still need and want a fair amount of parental direction as well as nurturing and caring.

Treatment Programs

If treatment rather than prevention is required, it often occurs in a more structured setting such as a treatment program. Treatment programs vary in type and setting for services provided. Settings include short-term inpatient crisis care, inpatient programs, day-care programs, residential treatment, halfway houses, and outpatient treatment programs. Although all programs make extensive use of group and individual therapy, they also "require some parental and/or familial involvement in the program and attempt to provide family counseling" in an effort to focus on the "underlying problems" in the family milieu (Kusnetz, 1986, p. 151). The more actively involved and supportive the family, the greater the chance of recovery for the substance abuser, if the abuser is motivated to stop the abuse. More successful adolescents recognize that they have a problem and want to participate in the treatment (Kusnetz). Those teenagers who are apt to be less successful are referred by the criminal justice system, have used drugs for a longer time and are more immersed in the drug culture, come from families where the adults are substance abusers, and have histories of violence and gang involvement (Kusnetz). However, regardless of the background of the abuser, motivation to change on the part of the teen and his or her family is the key to improvement.

Everyone has different ideas on how to solve the drug problem. These vary from drug legalization to the execution of dealers. What we are doing now in our legal system does not seem to be working. On the other hand, strictly social interventions are not enough either. As mentioned earlier, any intervention has to include multiple foci—not the least of which is the family (Daroff, Marks, & Friedman, 1986). In addition, teens and preteens need to receive accurate information on the effects of drugs—not only scare tactics designed to frighten them into avoiding drugs. This type of tactic perpetuates the "information gap" the counterculture of the 1960s experienced. We also need to consider the possibility that we will *never* totally stop substance *use*, and that perhaps we should prepare our children and adolescents to be wise decision makers with respect to taking drugs and avoiding substance *abuse*.

References

Ball, G. (1974). *Human development program: Level V activity guide*. LaMesa, CA: Human Development Training Institute.

Beschner, G. (1986). Understanding teenage drug use. In G. Beschner & S. Friedman (Eds.), *Teen drug use* (pp. 1–18). Lexington, MA: Heath.

Borton, T. (1983, April 25). Pressure to try drugs, alcohol starts in early grades. *Weekly Reader*. Middletown, CT: Xerox Educational Publications.

Brook, J.S., Whiteman, M., & Gordon, A.S. (1983). Stages of drug use in adolescence: Personality, peer, and family correlates. *Developmental Psychology, 19*, 269–277.

Brook, J.S., Whiteman, M., Gordon, A.S., Nomura, C., & Brook, D.W. (1986). Onset of adolescent drinking: A longitudinal study of intrapersonal and interpersonal antecedents. *Advances in Alcohol and Substance Abuse, 5*, 91–110.

Business Research Publications. (1987, September 15). Education department starts school year with "Challenge" public service campaign. *Substance Abuse Reports, 18*(16), 3–4.

Daroff, L.H., Marks, S.J., & Friedman, A.S. (1986). Adolescent drug abuse: The parents' predicament. In G. Beschner & A.S. Friedman (Eds.), *Teen drug use*. Lexington, MA: Heath.

Dembo, R., Blount, W.R., Schmeidler, J., & Burgos, W. (1985). Methodological and substantive issues involved in using the concept of risk in research into the etiology of drug use among adolescents. *Journal of Drug Issues, 15*, 537–553.

Dinkmeyer, D. (1973). *Developing understanding of self and others manual*. Circle Pines, MN: American Guidance Service.

Glickman, N., & Utada, A. (1983). *Characteristics of drug users in urban public high schools*. Rockville, MD: Project Report to National Institute on Drug Abuse, Grant No. H81 DA 10657.

Goldberg, S. (1982). *Clinical neuroanatomy made ridiculously simple*. Miami, FL: MedMaster.

Goodstadt, M.S. (1980). Drug education—A turn on or a turn off? *Journal of Drug Education, 10*(2), 89–99.

Gordon, T. (1970). *P.E.T.: Parent effectiveness training*. New York: Wyden.

Hawkins, J.D., Lishner, D.M., & Catalano, R.F. (1985). Childhood predictors and the prevention of adolescent substance abuse. In C.L. Jones & R.J. Battejes (Eds.), *Etiology of drug abuse: Implications for prevention*. NIDA Research Monograph 56, 75–126.

Horan, J.J., & Williams, J.M. (1982). Longitudinal study of assertion training as a drug abuse prevention strategy. *American Educational Research Journal, 19*(3), 341–351.

Hutto v. Davis, 454 U.S. 370 (1982).

In re Gault, 387 U.S. 1 (1967).

Inciardi, J.A. (1986). Getting busted for drugs. In G. Beschner & A.S. Friedman (Eds.), *Teen drug use*. Lexington, MA: Heath.

Jalali, B., Jalali, M., Crocetti, G., & Turner, F. (1981). Adolescents and drug use: Toward a more comprehensive approach. *American Journal of Orthopsychiatry, 51*, 1.

Johnston, L., O'Malley, P., & Bachman, J. (1984). *Highlights from Drugs and American High School Students, 1975–1983*. Rockville, MD: U.S. Institute on Drug Abuse.

Julien, R.M. (1978). *A primer of drug action (2nd ed.)*. San Francisco: Freeman.

Kandel, D.B., & Yamaguchi, K. (1985). Developmental patterns of the use of legal, illegal, and medically prescribed psychotropic drugs from adolescence to young adulthood. In C.L. Jones & R.J. Battejes (Eds.), *Etiology of drug abuse: Implications for prevention*. NIDA Research Monograph 56, 193–235.

Kusnetz, S. (1986). Services for adolescent substance abusers. In G. Beschner & A.S. Friedman (Eds.), *Teen drug use*. Lexington, MA: Heath.

Lewis, J.A., Dana, R.Q., & Blevins, G.A. (1988). *Substance abuse counseling: An individualized approach*. Pacific Grove, CA: Brooks/Cole.

Mandel, J., & Feldman, H.W. (1986). The social history of teenage drug use. In G. Beschner & A.S. Friedman (Eds.), *Teen drug use*. Lexington, MA: Heath.

National Institute on Drug Abuse. (1984). *Parents: What you can do about drug abuse*. Washington, DC: NIDA, U.S. Government Printing Office, DHHS Publication Number ADM–1267.

Ray, O., & Ksir, C. (1987). *Drugs, society, and human behavior*. St. Louis, MO: Times Mirror/Mosby College Publishing.

Schonberg, S.K., & Schnoll, S.H. (1986). Drugs and their effects on adolescent users. In G. Beschner & A.S. Friedman (Eds.), *Teen drug use*. Lexington, MA: Heath.

Shore, M.F. (1985). Correlates and concepts: Are we chasing our tails? In C.L. Jones & R.J. Battejes (Eds.), *Etiology of drug abuse: Implications for prevention*. NIDA Research Monograph 56, 127–135.

Swisher, J.D., Nesselroade, C., & Tatanish, C. (1985). Here's Looking at You Two is looking good: An experimental analysis. *Journal of Humanistic Education and Development, 23*(3), 111–119.

Tinklenberg, J.R. (1973). Alcohol and violence. In *Alcoholism: Progress in research and treatment*. New York: Academic Press.

U.S. Department of Health and Human Services. (1984). Publication No. (ADM) 84–1291. *Alcohol and health: Fifth special report to the U.S. Congress*. Washington, DC: U.S. Government Printing Office.

Appendix 16

END

U.S. Dept. of Education

Office of Education
Research and
Improvement (OERI)

ERIC

Date Filmed

March 21,1991